INTEGRATING DISABILITY MANAGEMENT:

An Analysis of Mayo Clinic's Current Disability Management Process

by

Kyleen R. Johnson

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About the Author

As a Communications Studies graduate with an emphasis in pre-law from Gustavus Adolphus College, Kyleen Rose Johnson initially pursued law school before recessing to gain experience as a legal assistant at a small firm in southern Minnesota. Her experience proved beneficial as she was given to opportunity to begin working within the Legal Department at Mayo Clinic in 2011. Kyleen obtained her Professional M.A. in Strategic Communication from the University of Minnesota's school of Journalism and Mass Communication. This paper is explores the disability management practices at Mayo Clinic and serves as the capstone project to her degree completion. Kyleen Rose Johnson is currently an Operations Coordinator in Recovery and Claims Services at Mayo Clinic in Rochester, Minnesota.

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Introduction

Every day, thousands of people become sick or injured across the country. For some, the illness or injury is short term; while for others it is unclear how long their aliment will last. For the working population, illness and injury, regardless of duration, can prohibit or limit their ability to perform their job duties, forcing them to take leave from work. This leave results in a loss of wages to the employee and loss of productivity to the employer. For many employers, the direct and indirect costs of absent workers and the need to improve employee productivity are critical competitive issues (Sedgwick, 2014; p.1). This is especially true in today's healthcare industry.

As the healthcare landscape continues to evolve, medical facilities and hospitals must make changes and adapt accordingly in order to remain relevant and competitive. For a prestigious private facility such as Mayo Clinic, this means analyzing all sectors of clinic operations under the three-shield model (research, education, and patient care) and determining where strategic improvements can be made. In 2013, despite disability management savings of approximately $17 million, just over 25% of Mayo Clinic's total work force population utilized one or more disability services offered by the clinic costing the company nearly $24 million (Liebenow, Kohlnhofer, 2014). This expense rose over $2 million from the previous year and due to Mayo's acquisition of several new health system sites and the expansion of claims administration to those work units, it is projected to continue to grow. This inevitable multi-million dollar expense is extensive and as such, is an area that has been identified for potential strategic improvement or reduction by leadership.

A disability management program has existed at Mayo Clinic since the mid 1980s with the most current model established in the late 1990s. The move to adopt a disability

management program was likely spurred on by new legislation in the mid 1970s set forth by the National Commission on State Workmen's Compensation Laws. According to H. Allen Hunt (2009) these laws sparked a "rapid escalation of workers' compensation costs" to employers (p. 3). The increase in costs to employers was significant and employers began to "search for ways to combat spiraling workers' compensation costs" (Hunt, 2009, p. 3). Soon after, pilot disability management programs began surfacing and their early successes demonstrated that control of workers' compensation and disability costs might be attained through the use of disability management tools. Though the concept and application of disability management has been around for several decades, today's programs must be periodically altered to accommodate the changing industries and practices, and no "best practice" model has yet been identified (Hunt, 2009, p. 4). Since Mayo Clinic is a self-insured and self-administered corporation, its disability management program is a unique in-house program constructed in accordance with Mayo's mission, vision, and values.

Disability management can encompass numerous components and is often administered differently from one corporation to the next. This makes the general term difficult to clearly define. Mayo Clinic defines disability management as "the proactive, employee-centered process of coordinating the activities of employees, management, claims, health care providers, and return-to-work coordinators to reduce the impact of injury, disability or disease on a worker's capacity to successfully perform his or her job" (RCS, 2013). As mentioned above, Mayo Clinic operates a unique in-house claims administration process. The in-house disability management process is currently divided between three departments within the clinic: Recovery and Claims Services (RCS), Human Resources (HR), and Occupational Health Services (OHS or Occ. Health). These three areas work together, as well as with safety personal, return to work

coordinators, rehabilitation case managers, employee supervisors, and sometimes legal counsel to ensure that each employee's unique disability situation is handled appropriately.

All departments play a key role in the administration in disability management at the clinic; however, there are obvious gaps in the collaborative system due to the division of program resources and limited or ambiguous communication between participating departments. Several recent internal survey responses revealed that some employees felt "lost" or "stuck" between conflicting collaborators while involved in one or more areas of the disability management program (RCS, 2013). These feelings led to confusion and ultimately negative experiences and survey responses toward a program that had formerly been internally admired. Negative perceptions combined with rising program costs are definite motivation for clinic leadership to assess the current in-house model.

This study will take a two-part approach while focusing on Mayo Clinic's current disability management processes. The first approach will involve a comparison of the current system to outside vendor offerings and procedures. The second approach will draw insight from current employees to target the communication gaps between interdepartmental collaborators. Research data may conclude that strategic improvements be made based on a choice between the following outcomes: (1) the determination to outsource Mayo disability management services to outside specialty vendor while remaining aligned with the clinic's vision and values, or (2) the determination to maintain the value driven in-house administration program and restructure to ensure the program meets improvement needs. Conclusions drawn from both approaches will assist in determining the most beneficial organizational course of action to support both Mayo Clinic employees in need, as well as corporate aims to work differently and reduce cost through strategic improvements.

Literature Review

Outsourcing Disability Management

As noted earlier, the current in-house disability management system provided approximately $17 million in cost savings to Mayo Clinic. This substantial savings from the internal disability management program is impressive and seemingly proof enough to, at minimum, maintain the current plan. Notwithstanding the substantial savings, absence and disability management vendors assert that an integrated practice model is the most beneficial program model to follow, and the clinic could potentially establish further cost savings by implementing a fully integrated plan.

Fully integrated disability management plans differ from Mayo's current model in several aspects. Sedgwick Claims Management Services, Inc., a disability and absence management vendor, outlines their current core IDM service model (See Figure 1) in their 2014 paper, "Integrating Disability Management." Sedgwick stresses that a "best practice model starts with a single contact claim intake system, integrated data collection, and specialty case management assignment for all leave of absence, FMLA, short and long term disability, ADA and workers compensations claims" (2014, p. 3). Competitor vendor MetLife, Inc. echoes Sedgwick's model, asserting their practice also employs a single point of intake for all leaves…" (Met Life, 2009, p.1).

Mayo Clinic's current intake process in Rochester is divided between three potential areas within the Clinic: RCS, OHS, and HR. Often times employees begin their services with one area but later need to be transferred to another area due to area constraints or an irregular separation of duties. Occasionally, an employee will speak with all three areas before their case

can be appropriately triaged to the correct intake unit as the disability management system can be overwhelming and the lines separating each area's responsibilities are seemingly blurred and confusing (See Figure 2). One employee stated they "would like to see more of a connection" between departments, as well as a "better understanding" of each area's roles (RCS, 2013).

Administration differences continue as Sedgwick also mentions that a successfully integrated system encompasses an integrated reporting or data collection system. "Integrating all absence information in a single data warehouse offers key advantages. An effective work system should contain comprehensive data on disability, workers' compensation, and absence cases, and track all of the SAW/RTW activities" (Sedgwick, 2014, p.3). This model supports and enhances the workflow and guarantees that all areas involved have the tools and information they need to operate smoothly. Mayo Clinic sufficiently collects and maintains metric information in relation to all aspects of disability management; however, this data is divided and stored between the three separate departments with very little information transmitted between the departments. This lack of information sharing potentially causes rework and could be a contributing factor to employee confusion and dissatisfaction.

Mayo Clinic lists Integrated Disability Management (IDM) on its list of employee benefits as having "components that include early identification of medical conditions that interfere with an employee's ability to do the job, prompt medical care, consideration of job modification, and an early return to work to the work place" (RCS, 2013). Sedgwick Claims and Care Management Solutions claims that core IDM encompasses "managing various types of employee absences, including workers' compensation, leave of absence, FMLA, short and long term disability and Americans with Disabilities Act (ADA)" (2014, p. 2). Sedgwick's paper also speaks to the advantages of having a consistent IDM program:

> "By combining all types of disability, leave of absence and workers' compensation under a consistent IDM program, companies can establish a single source for claims intake, improve overall employee experience, manage both occupational and non-occupational disabilities more effectively, and see a comprehensive view of all absences in a single reporting program" (2014, p. 2)

When applying the Sedgwick definition of IDM, Mayo's current program does not meet the necessary guidelines to be considered a true IDM program. Being truly integrated involves having all leaves of disability and absence management handled in one place, by one group. Promoting this practice under the Mayo umbrella would potentially allow a streamlined process to form and eliminate the "lost" feeling in unsatisfied employees. Joanne Sammer (2006), a business writer for the Society for Human Resource Management, further discusses the gap between departments in her HR Topics and Strategies segment *Disability Management Outsourcing.* She states:

> "In many companies, disability programs are handled by a number of people in the organization. Although primary responsibility usually resides with the employee benefits area, others in HR, employee or labor relations, and even the legal department can also get involved. Moreover, if a company wants to integrate disability management with its workers' compensation management and return-to-work programs, individuals from risk management, occupational health and safety, and finance may also be onboard. This scattered nature of disability management is another reason why companies look to outsource this activity. After all, outsourcing can help a company to gather all disability-related information for perhaps the first time. Only with that type of robust information

and data can companies make appropriate decisions for managing the costs and effectiveness of disability management" (2006).

In short, integrated vendor clients benefit from the organization and flow of an integrated disability management system. Mayo Clinic and its employees could reap similar benefits through either use of an integrated vendor or a restructured internal system that allows open communication with all areas involved with disability management.

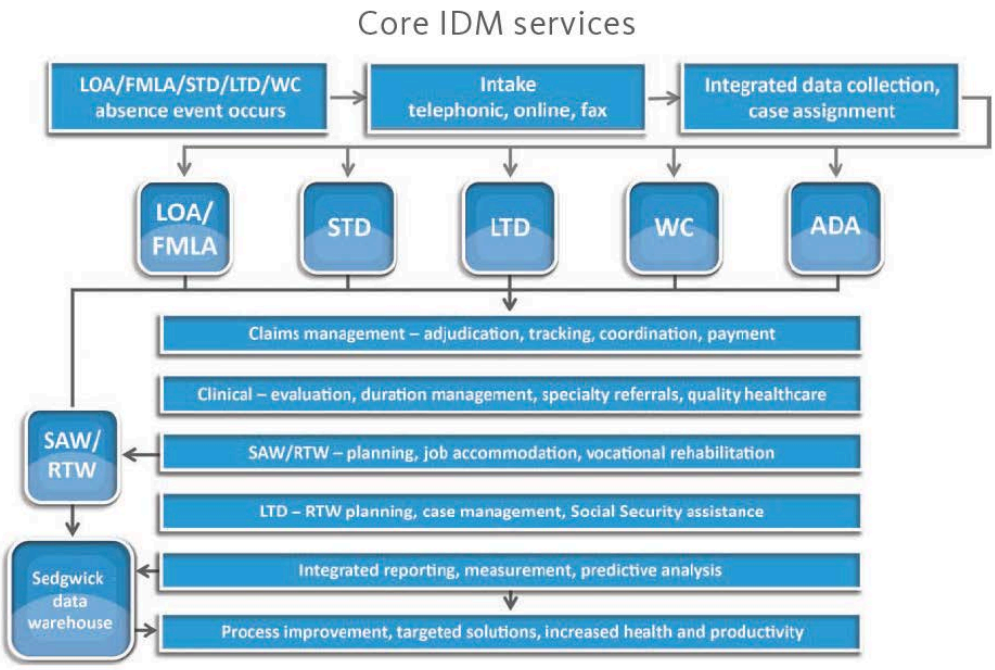

Figure 1. Sedgwick Claims and Care Management Core IDM Services Model (Sedgwick, 2014, p.3)

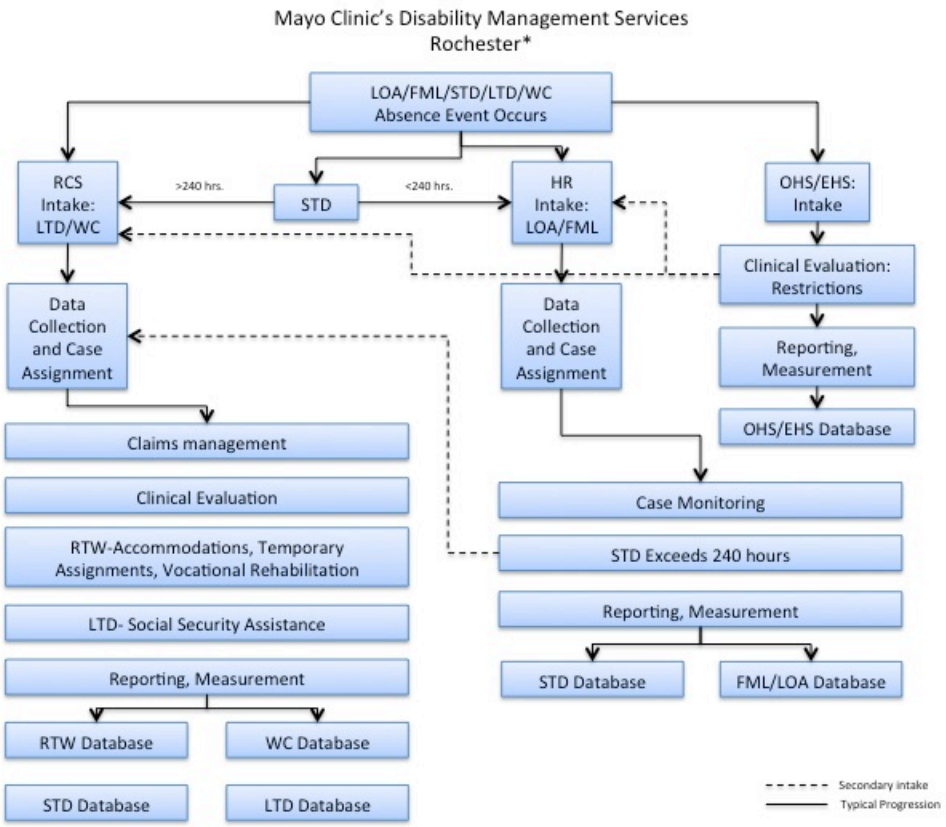

Figure 2. Mayo Clinic Disability Management Services Model

Shared Mental Model & SBAR Tool

Though there is ample evidence to support the pursuit of a vendor partnership, corporations must also consider company goals and values before restructuring a process. Charlie Fox, the President and CEO of DMEC asserts, "When an employer outsources disability or absence management programs/functions, it needs to exert the extra effort to get its vendors integrated around the same goals and aligned protocols" (DMEC, 2013, p. 5). If a corporation and a vendor are able to establish an effective communication concept, understand company structures and benefits, efficiently collaborate to work toward common interests, outsourcing is a possibility. On the other hand, current internal Mayo disability management areas already have an understanding of the company's structure and benefits, as well as share certain goals and interests. Making small improvements and building-up a stronger shared interdepartmental communication system at Mayo would eliminate the need to outsourcing.

A shared mental model is a process held by members of a team or group "in which team members can reason not only about their own situations, but the status and activities of the other members of the team and progress toward its goal" (Yen, et. al., 2003, p. 1). Mayo Clinic operates under the slogan "one Mayo;" i.e.: one team. Transparent communication between Disability Management departments would allow Mayo to realize a shared mental model approach and create seamless communication within the system. The researchers in Yen's study conducted a theoretical communication experiment similar to a military test mission. The experiment consisted of two teams (red and blue) of three individuals with limited assigned abilities. Teams needed to effectively communicate their different assigned abilities and use their shared knowledge, or shared mental model, to correctly anticipate their opponent's moves and reach the enemy base without detection. The blue team effectively employed two communication

strategies, with the "shared" decision-theoretic communication tactic being the most successful (2003, 7-8). Yen *et al.* also explains how shared mental models actually extend individual mental models to the team context rather than singling out an individual. In a shared context situation, the entire group is able to realize a difficult or unusual situation and benefit from the shared know how (2003, p. 2).

Though the health care industry is not simulating military exercises, it is necessary that different groups communicate efficiently in order to comply with the clinic's mission to always put "the needs of the patient first" (Mayo Clinic, 1864). This means employees must understand each section or department's roles and effectively transfer information. Better communication between employees leads to better communication with patients and an overall better practice. Mayo already has a communication tool in place to assist with effective person-to-person and department-to-department communication in the clinical setting. The SBAR communication model is a device that medical providers uses when facilitating patient transfers from one area to other or passing off patient information during shift changes or patient discharges. The SBAR model, implemented in 2001 by the National Patient Safety Goal[1], follows this template:

> "S" (situation) state what is going at the present time, when it started and what warranted the communication.
>
> "B" (background) explain the situation. Include the circumstances leading up the communication.
>
> "A" (assessment) tell what you think the problem might be.
>
> "R" (recommendation) state what you think should be done to correct the problem (Mayo Foundation for Education and Research, 2013)

[1] NPSG's are created by the Patient Safety Advisory Group, a committee of medical professionals who address patient safety in healthcare settings.

While this model is slowly beginning to appear in non-clinical settings, fully implementing this communication tool in the business and administrative side of the clinic would allow for clear, formal communication to pass between individuals and groups and assist in creating a shared mental model for the "Mayo IDM Team" to embody.

Change Management and the ADKAR Model

The idea of using a communication tool to create a shared mental model may not be revolutionary at a facility such as Mayo Clinic, however, it is nonetheless still difficult to effectively enact and productively use in the conservative administrative side of the Mayo community. With any new idea or proposal there is often some degree of pushback and it is necessary to formally address and preemptively prepare for those who are hesitant to change. Addressing change within the Clinic is essential regardless of the complexity of the change. In this scenario, a change in communication between departments is essential in order to support improvements in the disability management process. Though it is seemingly not well known outside of Mayo Clinic leadership, an organizational change management plan exists to assist with the preparation, management, and reinforcement of corporate wide changes. Mayo's quality academy defines change management as the "process, strategies, and activities that support organizational and personal transitions from the current state to the desired future state in order to successfully achieve and sustain the desired business vision and strategy" (Mayo Clinic, 2014). To effectively manage change within the Mayo community, the Clinic has adopted the use of Prosci's ADKAR model.

The ADKAR Model

A*wareness* of the need for change

D*esire* to support and participate in the change

K*nowledge* of how to change

A*bility* to implement required skills and behavior

R*einforcement* to sustain the change

The ADKAR model is a framework for understanding and implementing change. In his book *ADKAR: a model for change in business, government, and our community*, ADKAR creator Jeffery M. Haitt explains that "ADKAR is a perspective on change that enables other change management tactics to have focus and direction" (2006, III). Haitt goes on to say that the ADKAR model is comprised of five parts: Awareness, Desire, Knowledge, Ability, and Reinforcement. These five elements together create the building blocks from which successful change can occur. All elements must occur in sequence and remain present in order the change to be successful and lasting (Haitt, 2006, 43, 60).

Every change is situational and it is important that a corporation with a strong community and culture limits the amount of change presented at any given time. Maintaining transparency and keeping the community up to date throughout the course of a change is critical to success. Efficiently utilizing the ADKAR model to manage change will ultimately increase the likelihood of the change project's success, accelerate the implementation of the change, minimize employee resistance, avoid unnecessary turnover or loss of valued employees, minimized any adverse impact to customers/patients, and builds up change tolerance within the company or organization.

Change Management and Disability Management

Outsourcing or restructuring disability management at Mayo requires several levels of change. Each level must be carefully analyzed and targeted accordingly so that each change is sustainable, productive, and beneficial to the overall organization. The author previously discussed the communication gaps separating the three departments involved with disability management at Mayo Clinic. Outside vendors seem to have a seamless process and consistent flow of information that allows them to create a truly integrated system. As there are three separate departments involved in the Mayo practice, discrepancies as to what the newly reformed "best practice" internal disability management process should look like are likely to occur. It seems as though Mayo has made efforts in previous years to create a more unified and all-encompassing system, however, much like with the national healthcare reform, differences in procedures and opinions have caused dissonance between one or more departments. In an effort to proactively reduce conflict, an organizational change management plan surrounding interdepartmental communication should be enacted as part of the plan to change and establish a truly integrated internal disability management system. Change is hard for any corporation, especially one with a strong community and culture, and it is essential to keep all areas involved up to speed as to what is happening as well as give reasoning as to why the modifications are necessary during the change process.

Rather than ignoring communication issues or creating more work by producing multiple "best practice" models for the clinic to consider, departments must be willing to compromise, set aside bias, create a shared mental model, and strive to build a truly integrated system that supports the mission and values of the clinic (Mayo Clinic, 2014). Leadership and the project management team assigned to develop the integrated program must identify the stakeholders

involved with the program changes (HR, RCS, Occ. Health, employees who utilize the program) as well as the impact the change will have on the organization. Once the individuals and areas and impact are identified, Mayo Clinic leadership would benefit from the use of the ADKAR model to help facilitate the change.

A – building awareness through communication of the clinic's need to restructure in order to remain relevant and competitive.

D – creating the desire for employees to support and openly participate in the structural change

K – sharing widespread knowledge of the restructure

A – provide the training and tools so employees have the ability to make the change

R – establish a formal benchmarking system to reinforce and encourage continued productivity of the program change.

Utilizing change management while encouraging a transparency and open communication between participating departments would greatly ease the transition and enhance the success of an integrated disability management program both internally or externally.

Research Questions

RQ1: Might outside disability management vendor survey research provide ample cost savings comparisons to justify the use of an outside disability management vendor?

RQ2: How do outside vendor disability management programs differ from Mayo Clinic's current model?

RQ3: Why hasn't Mayo Clinic moved toward creating a truly integrated disability management system?

RQ4: How can Mayo Clinic effectively eliminate the communication gaps between collaborating departments within the program and effectively create its own truly integrated system?

Methods

Phone Survey

Phone surveys were conducted to assess options and potential cost saving of potential outside disability management vendors. The questions were targeted around the services each vendor offered, as well as the vendor's average cost savings to corporations who implement integrated disability practices (see Appendix 1 for survey response notes). The surveys were conducted between the hours of 9:00 a.m. and 10:00 a.m. or 12:00 p.m. and 1:00 p.m. central standard time over two, one-week periods. Initial contact was made during the week of April 7 – April 11, 2014, with follow-up contact being made from April 21 – April 25, 2014. Participants were contacted based on a proposed sample list of potential vendors compiled by the Recovery and Claims Services section of the Legal Department within Mayo Clinic. All participants were contacted via telephone.

Interviews

Intensive interviews were conducted by the author to discuss the current disability management processes at Mayo Clinic and assess potential rationale behind the program's current state of affairs. Interview participants were Mayo Clinic employees currently involved in different supporting areas of the disability management program. All participants were selected based on their knowledge of the clinic's current disability management program. Each interview began with the question: What is Disability Management? After the initial question, interviews were relatively unstructured as to allow the interviewer to customize the interview questions based on the participant's responses. Interviewer addressed two separate topics through

questioning: Disability Management at Mayo Clinic and Interdepartmental Communication at Mayo Clinic.

Interview "A" occurred on March 27, 2014 at 1:30 p.m. and lasted approximately one hour. Participant is a female Return-to-Work Coordinator in the Recovery and Claims Services section of the Legal Department at the clinic. Interview was conducted in a conference room in the participant's local office area for convenience. Pre-screening research provided knowledge that participant has over thirty (30) years of experience working with Mayo Clinic's disability management processes (See Appendix 3).

Interview "B" occurred on April 11, 2014 at 10:30 a.m. and lasted approximately forty minutes. Participant is a male doctor in Preventative Medicine at the Clinic. Interview was conduct in a medical conference room near the doctor's rotation area for convenience. Pre-screening research provided knowledge that doctor has five (5) years of experience working with employees in Mayo's disability management program (See Appendix 4).

Interview "C" occurred on April 21, 2014 at 11:00 a.m. and lasted approximately one hour. Participant is a male doctor in Occupational Health Services as well as the Medical Director of Safety at Mayo Clinic. Interview was conducted at local coffee shop of participant's choosing. Pre-screening research provided knowledge that participant has twenty years of experience working with Mayo's disability management program and seventeen years experience working with disability management at a separate organization (See Appendix 5).

Focus Group

A focus group of Mayo Clinic employees took place on Friday, May 16, 2014 from 11:45 a.m. to 1:15 p.m. A total of ten Mayo Clinic employees from various clinic work areas were

selected to participate in the session. All employees who participated in the focus group met the following criteria:

- Are current Mayo Clinic employees
- Are knowledgeable and aware that Mayo Clinic utilizes an in-house disability management program
- Communicate with departments outside their own daily

Participants who met the sample criteria were contacted and recruited via email to participate in a one to two hour session with the moderator and research facilitator. The group sample was comprised of seven female participants and three male participants, aged 27 - 50.

A member of the Recovery and Claims Department served as moderator. The moderator was provided with a set of base questions but encouraged to divert from the questions in order ask for more elaboration and maintain efficient direct conversation. The dialogue from the focus group was recorded with the consent of the participants and the research facilitator prepared a transcript. All participants were assured they would remain anonymous and each was assigned a letter to ensure no names or identifying information would appear on the transcript. Lunch was provided as compensation for the group member's time.

Results

Phone Survey

In total, eighteen corporations were contacted with seven fully complete survey responses for 38% response rate (See Appendix 2). Of the initial contacts, three (16%) resulted in completed interviews, while thirteen (72%) transferred the questioner to another area or voicemail and two did not pick up or transfer to voicemail. The goal of the phone survey was to

acquire information regarding outside vendor disability management services and compare those services to Mayo Clinic's current practice. Simple analysis of survey question number 3 addresses the author's research question 1 (RQ1) but does not allow any cost savings conclusions to be drawn, as only two respondents were able to provide the questioner with numerical information. Based on participant response, the majority of participants were not able to provide the questioner with concrete numerical figures as cost savings varies significantly from company to company. In a substantive comparison of services offered, many outside corporations reported providing similar disability management services to Mayo Clinic. Five (5) of seven (7) participants specifically reported providing Long Term Disability and Short Term Disability Services. Four (4) participants specifically mentioned providing workers' compensation services and seven (7) participants mentioned their corporation provided either "Integrated Disability Management (IDM)" or "Total Absence Management (TAM)." Mayo Clinic is not able to offer a truly integrated disability management or total absence management (administration of all aspects of leave or absence management from disability and sick leave to military leave, etc.) services based on our current program design. However, limited results depict that truly integrated services would benefit Mayo's management program and potentially provide a cost savings benefit to the corporation.

Interviews

After the content of the interviews was dissected, several similarities were detected. (1) All three participants, Ms. Jane Ryan, Dr. Andrew Vaughn, and Dr. Greg Couser, found it difficult to pinpoint an exact definition of disability management. Disability management is a complicated service comprised of various subservices; the definition is not consistent in sources. (2) All three participants cited communication issues within the clinic, primarily within the

disability management sector. (3) All three participants vehemently agree that disability management services should remain an in-house managed service. RCS manager Jane Ryan (Participant "A") stated:

> "A lot of people think that it is better to have kind of an insurance company 'TPA' [third-party administrate] outside of the organization because they may have to deal with difficult employee issues, denying claims, that kind of thing so they want to keep that separate so they can be the bad guy and not the employer. I personally believe that if you have the right philosophy for claims administration there's really no need to be adversarial, I think you can deliver difficult messages in a less adversarial way. But some companies just because they can, operate that way, I think. But here, our philosophy when we brought it in-house was, we have a claims staff who is dealing with their colleagues and that we want to administer benefits fairly. One advantage I think by administering benefits in house is that, even if you deny a claim, there is another benefit that an employee is entitled to so it behooves us to make sure that it's the right benefit for the right reasons and so we are providing a service to our co-workers. I think it's healthier, we're always available to employees--you're not waiting for a phone call back from an insurance company, I hope that it promotes more sensitivity and empathy (Appendix 3).

Dr. Andrew Vaughn (Participant "C") elaborated further and discussed the values associated with maintaining the in-house model.

> "..Because it's all about values, and because it's about a sense of belonging, and the… proximity of the workforce and feeling like you're part of the team. You owe it to your coworkers to be there and help manage the business and so forth. What it comes down to is do you have a relationship with anybody who can reinforce that and can encourage that and can facilitate that connection and that emotional drive to come back to work. If you are a disembodied voice at the end of the phone who doesn't understand the corporate culture, doesn't know any of the names, doesn't have any sense of the, the values, or who doesn't have a clear sense of the values… the phrase is cultural milieu. It's hard. If you

> get a call from your coworkers, just 'hey Joe, how you doing?' or you get a call from your supervisor periodically to check in…that makes a big difference. You're still part of the group, you haven't been thrown to the side, they appear to want you back. Gee, you know, that's kind of nice. That is more difficult to do if you have outsourced it to a telephonic organization that has no particular connection or knowledge or sense of who you are. If you have people that have been acculturated, who come into these roles, and are, you're consistently talking to one person…. basically you have a relationship with somebody, and you're far more likely to have an effective result." (Appendix 5).

Our corporate culture takes pride in its close-knit community like environment and keeping the services in-house follows the Mayo mission and values. With Ms. Ryan, Dr. Vaughn, and Dr. Couser all viewing the in-house model as a benefit to both Mayo Clinic and its employees, it is pertinent that the in-house model be measured. Not only does maintaining the program and offering a restructure give Mayo the opportunity to create an innovative and admirable strategic program to benefit both employee and employer, but it also aligns with the established culture.

Focus Group

The focus group brought together several individuals from various departments within the clinic (legal, HR, RCS, general services, etc.). This proved beneficial, as the author was able to gain a variety of insights surrounding communication within the Mayo Clinic community. Participants we able to provide a significant amount of information about disability management at the clinic however the main focus of the discussion was geared toward communication. The general perspective of clinic communication, all participants agreed that Mayo as a corporation does an excellent job of providing news and clinic happenings to clinic employees both locally as well as nationally. One participant said:

"I feel like our news center on the Mayo Intranet does a really good job of covering big events…at all the places that are going on. If there is a big event in Florida that's important, it's up on that page…and there are a lot of community interest pieces too where there is somebody in a small town who had their life saved because they went to Mayo Clinic, and so you get to hear all the different pieces and I think they do a good job with that."

Participants, though very positive regarding general communication at Mayo, did offer a few suggestions for potential improvements. One participant discussed the desire for a corporate wide platform for project sharing. This platform could potential eliminate waste and promote more collaborative work between departments. As the discussion turned toward communication between departments the tone of participants changed. Several participants testified that interdepartmental communication is one area that Mayo needs to focus on and improve. Another participant went as far as to say, "I mean I know there are committees everywhere but the over sight is mind boggling…the lack of communication between departments. I think there is a lot of that kind of communication that we aren't real good at." The honest feedback and group consensuses highlights the fact that interdepartmental communication at the clinic is truly a problem that needs immediate attention.

Limitations and Future Research

Phone Survey

During the initial week of the phone survey, the author served as the survey questioner for the vendor phone survey. The first two days of questioning did not produce adequate results, causing the author to feel doubt and frustration. The third day of cold calling produced more

adequate results but the questioner veered from the template slightly and potentially influenced the responses of the participants. In order to remain non-influential for the remainder of the survey, the author recruited an additional caller to complete the remaining weeks survey calls. The second questioner followed the script exactly and as such, perhaps did not receive the same amount of information had she veered.

Interview "B"

Due to technological inconvenience during the interview session with Interview "B" the full recording was not available for transcription and the author needed to rely on memory and hand written notes taken a few days prior to transcription. A follow-up interview was to be scheduled in an attempt to re-address some of the more in depth communication topics, however the participant was not available for a meeting until after the scope of the project was complete.

Discussion and Recommendations

The objective of this study was to establish the most efficient and beneficial disability management route for Mayo Clinic to follow and recommend a strategy for future action. The author originally predicted two alternative potential outcomes to the research (1) the determination to outsource Mayo disability management services to outside specialty vendor while remaining aligned with the clinic's vision and values, or (2) the determination to maintain the value driven in-house administration program and restructure to ensure the program meets improvement needs. The author also proposed several research questions to explore.

RQ1: Might outside disability management vendor survey research provide ample cost savings comparisons to justify the use of an outside disability management vendor?

Survey results did not prove sufficient enough evidence to determine cost savings to Mayo through the outsourcing and implementation of an integrated disability management

program. Survey results did however provide some insight as to the benefits of an integrated disability management system a competitive framework of service information in which to compare its service offerings.

RQ2: How do outside vendor disability management programs differ from Mayo Clinic's current model?

Mayo Clinic, despite its efforts, is not currently operating under a truly integrated disability management program.

RQ3: Why hasn't Mayo Clinic moved toward creating a truly integrated disability management system?

In the simplest sense, Mayo Clinic is lacking in interdepartmental understanding and internal communication. "We don't do a good job of communication here…we have silos…we don't communicate within the silos" (Vaughn, 2014). The consistency between the initial internal survey results, the in-depth interview, and the focus group results, depict an issue worthy of immediate attention. Learning to communicate more effectively and breaking down the barriers or "silos" is key to eliminating the strain on Mayo's potential progress. More effective communication will create more transparency and a better flow of information and resources. Though the clinic does not currently have a program in place to provide true integrated disability management services to its employees, Mayo does have the ability to strengthen it's internal communication practices and provide a platform or standard of information sharing. Fluid and efficient communication is a necessary resource in developing a successful and cost effective program.

RQ4: How can Mayo Clinic effectively eliminate the communication gaps between collaborating departments within the program and effectively create its own truly integrated system?

Streamlining communication and eliminating the communication gaps segregating departments is the first area the clinic should focus on. Mayo takes pride in being a patient centered practice, but in order to better communication with our patients, Mayo must first adapt and better communicate within itself. Better internal communication can only benefit external communication. Conducting further focus groups aimed at targeting both disability management leadership and general employees could potentially help identify further communication issues with the program.

Restructuring to design a unique in-house integrated disability management program is a significant change to the organization. With every change, there is the possibility for conflict and pushback. Proactively planning and managing change within the organization while maintaining consistent and clear communication between all areas and individuals involved would greatly enhance the potential success of an the program.

Lastly, interview results suggest, an efficient disability management program should benefit both the organization as well as the members of its workforce (Appendix 3). Mayo Clinic stands by its mission and value of providing a patient centered practice. When an employee becomes disabled, they transition from an employee to a patient, and as a patient Mayo Clinic stands by its promise to ensure that “the needs of the patient come first.”

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Appendix 1.

Disability Management Phone Survey Guide and Questions

Survey Guide:

Hello my name is _____ and I am graduate student participating a research study about disability management at the University of Minnesota. I have a few questions about the disability management services your company provides and I am wondering if you would be able to answer a few questions or direct me to someone who might be able to assist me?

Questions:

1. What type of Disability Management services does your company offer?

2. Does your company offer any other types of services? What are they?

3. If a company is currently running a divided in-house disability monitoring system, what are the benefits of outsourcing?

4. On average, how much could a company potentially save by implementing an integrated disability management program with your corporation?

5. What sort of metric system does your corporation use to determine cost savings?

Appendix 2.

Disability Management Phone Survey Responses

(Attached)

Appendix 3.

Interview Transcript A

INTERVIEW TRANSCRIPT A

I: What is disability management?

P: That's difficult.

I: We are discussing disability and absence management; first off what are the differences?

P: Well disability management (DM) really is managing employees with disability, disability issues…short term disability long term disability, workers comp., temporary and permanent disability, accommodations…so anything to do with a disabled employees.

Absence management expands that to look at all leaves…it could be military, personal, educational leaves, any absence that takes an employee away from their job. In my mind those are the distinctions.

I: At times they do go hand-in-hand?

P: Right, and I don't know everything you have read but in my experience with health and productivity and absence management. is the trend is to move toward having total abs mgmt. housed together. So you are dealing with anything that takes the employee away from work. That seems to be the best practice. So any EE who needs to be away from their job or the workplace has kind of a one stop shop and EE can call and report an absence and that area will triage accordingly.

I: In terms of Disability Management, How and why did Disability Management start at Mayo Clinic?

P: [Raises hand]. It was me.

I: You?!? Wonderful.

P: So at Mayo, I mean there is a lot of history here but…before Mayo was one entity there was Methodist Hospital as an organization, St. Mary's was an org., Mayo was one, Charter House was a separate one. All distinct, all had different programs, all different processes, different philosophies. I started at St. Mary's in 1986, my job was return-to-work coordinator. So I coordinated RTW activities for every employee that had a condition whether it was occupational or not occupational. Methodist at the time provided services to people with work related injuries. Charter House operated similarly, at Mayo, I have no idea, no one knew what Mayo was doing, there wasn't a program. The year that I started was the year that Mayo moved and took everyone under its umbrella. Still separate organizations but under one entity and it has since, of course, transformed into what it is today.

I: One Mayo!

P: [Laughs] Yes. One Mayo….so there was a need as services were all done differently. I was in HR, Methodist and Charter House services came from Occupational Health, and Mayo was maybe done by personal services and benefits maybe by HR Reps but not a defined program. So we brought in an outside consultant…we met for like a year and a half and all agreed to disagree about the best approach…so we brought in the consultant. He looked at what was good about each program and presented a proposal and basically adopted what St. Mary's practice was doing at the time, which is that we provide services to any EE. So that was the beginning of a common approach across campuses. We had previously been nominated as a best practice, our return to

work program has received recognition both nationally and internationally and Mayo has previously been really supportive with efforts to move forward to better accommodate and manage employees.

I: I know we have talked about in the past how RTW programs and in-house DM programs are not particularly prevalent in every corporation, is there the potential to out-source?

P: There is the potential to out-source. Especially in companies who are smaller, they may not have somebody who can help manage the process. Sometimes outside consultants will come in and provide services to their employees…so they'll interact with the supervisor, usually with a TPA or outside insurance company, usually a healthcare provider, so they'll be that person who brings all the resources together.

For RTW, I think a lot of mid-size to large employers find it beneficial to have people inside who are familiar with the employer philosophy, and jobs.

I: And DM?

P: Not that's a different animal. Claims administration here is in-house. That is very uncommon. We are not only self-insured but self-administered. There are a lot of companies who are self-insured but not self-administered and there are pros and cons to that. A lot of people think that it is better to have kind of an insurance company TPA outside of the organization because they may have to deal with difficult employee issues, denying claims, that kind of thing so they want to keep that separate so they can be the bad guy and not the employer. I personally believe that if you have the right philosophy for claims administration there's really no need to be adversarial, I think you can deliver difficult messages in a less adversarial way. But some companies just because they can, operate that way, I think. But here, our philosophy when we brought it in-house was, we have a claims staff who is dealing with their colleagues and

that we want to administer benefits fairly. One advantage I think by administering benefits in house is that, even if you deny a claim, there is another benefit that an employee is entitled to so it behooves us to make sure that it's the right benefit for the right reasons and so we are providing a service to our co-workers. I think it's healthier, we're always available to employees--you're not waiting for a phone call back from an insurance company, I hope that it promotes more sensitivity and empathy. Not sympathy so much, but empathy for employees who are struggling and that we are here to provide services and benefits.

I: Wonderful. To your knowledge are there strong opinions here that discourage or encourage our in-house DM program.

P: Oh sure, I mean there are individual opinions, there are still people who believe that employees who are disabled are malingerers, um don't deserve to be treated the same. Often those opinions are changed rapidly when the person who held that…we've had employees who have gotten injured who will show up and say I was one of those people who wasn't helpful or supportive but it happened to me and now I understand how important that support it. We do have supervisors and managers who operate differently and don't want to accommodate. It's cutting through the bias and dealing with the lack of understanding. Some of it is education, education will take care of it, other it's a mindset that isn't going to change.

I: On the other side there are people who are very supportive, correct?

P: Yes, and I will say that the reason that Mayo Clinic has a best practice program is because of management. There are great managers here who are willing to mentor and support and take issue with those who are not supportive. I hate to generalize this way but I do think that because of our geography and Mayo's overall philosophy...we're in patient care, we take care of patients

we should also take care of each other. Sometimes it's ironic that people who take care of patients don't want to take care of their own.

[Pause]

I: In terms of metrics, is that how we justify our programs? Based on Metrics?

P: We do have customer surveys, we have industry benchmarks, RTW has a difficult time with metrics, we can measure RTW rate but there are a lot of soft numbers associated. The value of keeping people in the work place is softer and more philosophical and although there have been studies done that say the quicker you return people to work the faster they recover and that is our experience anecdotally. And the longer people are off, the less likely they are to return. When we started this program we didn't really do measures. So we don't really have a before and after. We have sort of an after, after, after, so we can't say we've saved this much money. Which is what an employer should be doing. Some people argue that when we bring people back to work, they're not fully productive so wouldn't it be better for them to stay home? The difference for us is that we are bringing people back to do productive work, they're not coming back to watch the clock. Transitional work has to be meaningful to the organization and to the employee. Some people argue that this hinders recovery because people like a cushy job, but that has not been our experience. You can take a look at our survey results, there are a lot of positive comments.

I: Are there any national benchmarks you can think of?

P: MPAC which is no longer operating. Watson Wyatt used to do a world at work. Insurance companies have some. They have traditional benchmarks based on claims and RTW management. We are trying to present to Mayo that it is an overall savings. There is a cost to providing the services but the return that you get is so much more because hopefully people are recovering faster and if we had a better system in place to show that I think that would show a

difference. For return to work metrics outside of a manual system which know one has time to do, I think that would go a long way in making cost savings more real and more supported.

[Pause]

P: I should mention one of the reasons we do what we do is to comply with the ADA. That's not the only reason but…you always think you should be able to appeal to people, it's like it really is the right thing to do. It's not rocket science, it makes perfect sense, we believe in workers therapy and we value our employees and they have expertise we have invested in as a company and these are people that want to work.

I: What are the benefits of an RTW program?

P: Employee morale, you preserve talent within an organization, you save money. Rather than pay disability benefits you are saving those by keeping people productive, works that needs to be done gets done, it is the right thing to do and it is in compliance with federal and state legislation, I think it is socially responsible rather than put people on social systems they don't need to be on, we have people productive and working to take care of their own people. Over all it is the right thing to do.

I: And that falls under Mayo's ideals…

P: Yes, Respecting the individual contributions even "the needs of the patient come first." These people need assistance. In terms of RTW, you don't negate a person's ability to contribute simply because they are disabled. That goes against everything the ADA says and we are a huge organization and we have to do more, it's our responsibility in the community. And that is one reason we offer a fairly generous RTW program, we are a huge employer in a small town, you have to do more, we have to do more. Other wise you've got people looking for jobs are on permanent disability, or unemployment and that's not the right thing to do. That doesn't mean

you can save everybody but the majority of people here want to work and we've employed them and we've supported them and we can find a way for them to contribute if they are able.

I: Do you think it is beneficial to have an in-house disability management program?

P: I do. I do, we are immediately accessible, we understand work needs, we can…we're kind of that liaison between management and the employee so we can be objective representing the employer but we are also advocating for the employee. We're making sure that we as an organization are in compliance. We respond more quickly. You can hire outside consultants but that requires really an orientation and I think a delay in services. It takes time to learn the supervisor, the work unit or employer philosophy, you're working with outside insurance company often you're running interference. The more quickly you can respond to an employee who is disabled, off work or about to be off work the less adversarial it is. So you don't run into a lot of the issues other companies do because there's no internal support system for the employee and the employee ends up feeling kind of abandoned.

I: Why? What is the push back to having an in-house DM program? How do people think it could be done better?

P: Potential cost savings. There is always going to be negative people and push back,

I: What would you like to see happen with the DM program at Mayo clinic?

P: I think we need to do more advertising and education. We tried to work together with HR but HR's not doing it. We could do better at promoting our program. One huge issue for us; and this comes from HR as well is that HR pushes a lot off on managers--managers are not well educated in this area. We could be more proactive and there are areas that we need to fix. We have brought Silver collaborations forward and have received limited support from HR. [Off the record example] We're reactive…do we wait for that to happen though? We don't want that

kind of notoriety. We're Mayo Clinic we should be setting the standard here not operating at it or below it. We could be a lot more proactive. We could do a lot more with health and productivity. Another problem is that we don't manage short-term disability. It is also currently tied to FMLA and I don't think it should be.

In terms of absence management, we learn a lot about people, we have the ability to direct people into appropriate programs, Mayo disease management programs. We could be connected. But we're not connected like that. We do work with safety but we could do more.

I: Should we be expanding our services to our Mayo Clinic Health System sites?

P: Yes, I think we should but it hasn't been very well supported. We provide some to some but there is no formal process.

I: Not supported because of time, cost, or commitment?

P: Just not supported internally, here we are ready and could go out, but there hasn't been a focused approach and we as a department can't do it alone. Depending on our level of involvement, consulting only…we wouldn't have to add staff. However as our caseloads grow we would need to add staff.

Appendix 4.

Interview Transcript B

INTEVIEW TRANSCRIPT B – Incomplete Transcript

I: I have been doing a lot of my own research but it is always nice to hear it first hand, just what is disability management in your eyes?

P: Oh it's a definition that's a tough one.

I: I know it's very hard to encompass because it's really not one that can be easily defined.

P: Well, and I might look at on a little bit different terms than other people may being that I am a physician and being in preventive medicine. There is a preventative framework of Primary, secondary and tertiary prevention. Primary prevention being more education and things being in place so that people don't even get off of work in the first place. So it's systems in place, that sort of thing. Secondary Prevention is more screening and early detection and trying to get on top of it early, and then Tertiary Prevention is preventing the downstream consequences from it. Which I think a lot of what are—when we're talking about traditional disability management is that, that you have—now you have a case that has been identified and you are trying to do everything you can, trying to being all the resources together to make sure that that person gets what they needs to get back to work and to productivity, that sort of thing.

I: Okay, and is -- there's a difference between disability and absence management?

P: Yeah, and sometimes—absence management you are talking about when people are not there at all…

I: Yeah

P: verses disability there's of course lots of different and various stages of impairments and I'm sure you've heard Jane and others say that just because people are impaired doesn't mean they are disabled, there is a whole conference based upon that concept and there are various gradations where people can be at work while on work restrictions which is so they're at work, they're not absent but there could also be a concept of presenteeism where they're not as productive.

I: Okay.

P: I don’t know if that answers your question but..

I: No, it does. It does. I’m just looking for a very general [air quotes] in your opinion what is it.

P: Yeah.

I: To your knowledge how did we start our own in house disability management program here at Mayo Clinic?

P: I have no idea I really don’t [laughs]. I mean I can tell you my background. I’ve been at Mayo for nine years, I’ve been in my current division for five and a lot of the efforts were long started before—I don’t know as much about the historical as the current and its even difficult to get a handle on the current state let alone the historical so I’m not the best person.

Appendix 5.

Interview Transcript C

INTERVIEW C

P: So, how can I help you?

I: What…I would just like to learn a little bit about disability management.

P: Ok.

I: In general

P: Ok

I: What you know about it, your role here at Mayo Clinic, in…involved with disability management, the…um…the goals for the programs here, what you would like to see done…uh, your views on communication in the Mayo clinic community. That…more of that line, not so much of solving a disability management sphere.

P: Ok, so. Ok so, umm…disability management in my view has two goals. One of them is to facilitate compliance with a variety of legal obligations that are imposed on employers. ADA is the obvious one, there are others.

I: Yes.

P: The second…umm…the second goal is to maximize the productivity of the workforce. Or, I should say to optimize the productivity of the workforce. So, there are two components to the impairment, disability, one is, two is – coup, couple of, sort of a shorthand way of thinking about it – there's absenteeism, in which the person is not at work at all.

I: Yes.

P: Which is a total loss of productivity. And then there is presenteeism, which you're familiar with.

I: Yes.

P: All right so that's the partial loss. Um, much easier to define absenteeism than presenteeism. But…

I: Yes.

P: ..The available studies that have been done, most of them by, well some of them by the Sloan school, um…would suggest that you're looking at some multiple of the lost absenteeism productivity…

I: Mmmhmmm

P: …attributable to presenteeism. Um…especially when it comes to things that are, uh quote minor in terms of how many people think of healthcare. So, for example, allergies.

I: Ok.

P: Um…people taking sedating antihistamines. There's some interesting studies out which basically show a fair bit of impaired performance… umm…and loss of productivity. Presenteeism.

I: Ok.

P: But nobody's absent.

I: Yes.

P: Right. And the other one of course is depression, most of which is undiagnosed and untreated. Um you can add to that anxiety. You can add to that social anxiety.

I: Mmhhhmm

P: All of which of course has a fairly profound impact on communication, right?

I: Yes.

P: In terms of the losses, umm, I've looked at different types of loss associated with disability and there's a huge range. Um, it's everything from, well, it's much of it is translatable into financial terms, but it's everything from replacement labor, which is very simple, to, uhh, indemnity payments, again very simple, umm and some and then a whole range of much less easily quantified, uhh, indirect expenses. So for example, taking supervisors away from their work in order to manage the, uh, labor shortage. Um, the increased incidence of injuries in people who are picking up the slack for whoever's absent.

I: Ok.

P: Uh, the corrosive effect on morale of having someone who is impaired on the job when that impairment is not appropriately managed.

I: Ok.

P: Ok, and, and the classic example there is the alcoholic. People cover up for the alcoholic very often, but when things get difficult, they get very irritated at having to do that.

I: Yes.

P: Stuff like that.

I: OK.

P: So, um, if you actually look at the direct expense, uh, and losses and you look at the indirect expense and losses, uh, it's anybody's guess what the actual ratio of those is. Um, my suspicion, my strong suspicion is, at least in my past experience, uh, it's somewhere between three- to five-fold. Now, I actually constructed a model, working with, uh, at the time it was Mercer & Associates…

I: Ok.

P: …and we put together, it was actually a very – it was actually pretty complex model– because when you try to actually nail down the costs, it becomes, well, the sort of thing is, if you are out of work, you can be out of work for two, three days, and everybody else picks it up. Maybe even a week. Maybe even a month. But at some point, your labor will be replaced…

I: Mmhmm.

P: …imposing additional cost. How quickly will that labor be replaced? In your job, my guess is you've got to be out of work for quite a while before somebody replaces you. If you're working on the line making widgets, and you're not present, the widgets don't get made; you will be replaced that day or the next day.

I: Yes, ok.

P: So, you, you get a, a very interesting difference in terms of the indirect cost depending upon the sector of the economy and the nature of the business. At Mayo, if we have a surgeon who is unable to operate, that's a huge loss.

I: Yes.

P: Now, the other surgeons might, in theory, be able to help pick up the slack. Of course this means you're paying overtime now to all the O.R. staff and your hourly employees, and you, so on and so forth. Um, but it gets pretty expensive pretty quickly. And yet, if Jane's out of work for a week, two weeks, three weeks, you probably get by. Is there a cost? Yes. Is there a loss? Yeah, but is it proportionately as large as the surgeon who ain't doing his cut? No, I don't think so. So, trying to put, uh, the dollar value on these things is, is problematic. The other, the other issue, when you start looking at that, the first– the next question you have to ask is: What's the

cause of the, of the, the disability? Is it truly disability? If someone has a sick child and elects to stay home because they don't have, their sitter won't take a sick child? Is that a disability?

I: In my mind? Well, alright, you know…

P: For purposes of the discussion. For purposes of the communication. If you're going to be communicating to somebody else, right? You have to know what they mean when they say disability.

I: Yes.

P: Or you have to define it for them.

I: Yes.

P: Right? Here is what I mean when I say disability.

I: Mmhmmm.

P: Could go either way on that one.

I: Yes, yes I could.

P: So if you look at short-term disability…

I: Mmhmm.

P: …and that, I'll define that for convenience's sake as disability of a week or less, what fraction of that would you reckon is actually medically related?

I: Oh, I'm not sure.

P: Well, there are numbers out there. There in the range of thirty percent.

I: Ok.

P: In other words, seventy percent of short-term absence actually isn't medically required.

I: interesting.

P: Is a mental health day a medical absence? No?

I: Well, is it diagnosed or not?

P: Is that the criteria?

I: From my understanding of short term disability. I work, I do not work with short-term disability at all. So…

P: Well, I mean this is, this is, this is a key question.

I: Ok.

P: So what you're really saying, what I, I think I hear you saying, is when you're proposing the, the criterion of disability— of, diagnosis—is what are the criteria…

I: Mmhmm.

P: …for calling something a disability? Well, why does it matter? Well, A). it matters for the conversation, but B). it's critical in terms of whether or not someone is eligible for any benefit. Right?

I: Mmhmmm. Yes.

P: All right, so let's talk about benefits for a moment. Benefits are incentives.

I: Yes.

P: To do what?

I: Work hard. Not everyone gets benefits. They're not a right…

P: Why? No. Why is it an incentive to work hard? If I work hard, and I never lose any time, what is the incentive for the benefit?

I: Ok, that's fair. Ummm…

P: Now, if I decide to go fishing…

I: Mmhmm.

P: …and I stay out for more than three days, I start getting paid again. So why isn't the incentive that, when I choose to go fishing and claim disability…

I: Mmhmm.

P: …I make sure it's worth three days? Or now, actually, more than a week...

I: Yes.

P: …for me.

I: Forty hours.

P: Right. So why isn't that my incentive?

I: [Sighs] Apparently, I'm just a very honest person, because I would never do that. [Laughs]

P: Well, what's—I'm not being dishonest—I mean, if, if you had a bad cold…

I: Mmhmm.

P: …say you have bad influenza.

I: Ok.

P: At the end of four days, or five days, you could drag your buns in here…

I: Mmhmm.

P: …and sniffle over in the corner, and pile up a huge pile of Kleenex. Or, you could decide you were gonna take another two or three days to get better and hang out at home and pile up the Kleenex at home. You know…

I: Yes.

P: …while you, I don't know, watch your kid, watch T.V., whatever.

I: Mmhmm.

P: Is one right and the other wrong? I mean, if you come to, come to work, you might spread the virus.

I: Yes.

P: So, or maybe not.

I: Mmhmm.

P: So, what d'ya think?

I: It's…

P: We're talking about how we manage disability now.

I: Yes, we are.

P: Yes, right.

I: Mmhmm.

P: So?

I: It's difficult. It really is difficult.

P: So, so, all right. So, you're going to communicate to all the people that got flu over the winter.

I: Mmhmm.

P: And you want to explain to them the appropriate use of their short-term disability benefit.

I: Mmhmm.

P: Whatcha going to tell 'em?

I: Well, from my understanding, and how I see the short – for example of short term disability—if I have the flu, and I am ill for three days and after three days I feel better enough to come in to work, I'm coming to work, because I have a responsibility to my co-workers.

P: You do.

I: That's my position.

P: So, so, where did you come to the conclusion you had to?

I: From having a work ethic and having a sense of responsibility. That's part of having a job, being employed.

P: It's a set of values.

I: Yes.

P: You suppose everybody shares those values?

I: No, they don't.

P: Ok.

I: But I share them, I have them. [laughs].

P: So, so, if you're trying to manage disability…

I: Mmhmm.

P: …in the population, and you're interested in driving behaviors similar to the ones that you, based on your values, would follow…

I: Mmhmm.

P: …why wouldn't you have a values based discussion in your communications around how to manage disability? Is disability anything other, or management of disability anything other than establishing and promoting and incenting a particular set of values?

I: Not everyone has the same values, and so…

P: Well. That's ok.

I: Yeah.

P: I mean I live in a democratic society, I can promise you that some of my values are different than yours, not to mention…

I: Yes. [Laughs.]

P: …anybody else I can point to.

I: Yes. Right.

P: Suppose I was to tell you in a previous life I actually managed a disability organization. We had, uh, somewhere roundabout three-thousand absences or greater than a week every year. Uh, we managed those in an attempt to minimize the amount of time, uh, off, and, um, my conclusion was—first of all we didn't try to manage anything less than a calendar week.

I: Ok.

P: And I will simply say that is a huge fraction of lost productivity.

I: Yes.

P: But I, I'll talk about that in a minute. For those people who were out more than a calendar week, there were relatively few people who were out for more than ninety days that we could really make much difference for.

I: Ok.

P: Uh, their reasons were, uh, some, some of them were terminal. You ain't gonna do anything for them.

I: Yeah.

P: Well, make 'em comfortable. Um, and the ones who were playing games were generally able to manipulate legal aspects of disability law and so forth to make it very difficult to actively manage them.

I: Ok.

P: There was nothing that a, a disability manager could do about them. The only thing that would make a difference from about thirty days out was the design of the benefits.

I: Ok.

P: So, when somebody goes out of work, at what point to you start – is it all about incentives – at what point to you start to provide short term disability? And do you prov- provide a hundred percent? Do you provide seventy percent? Do you provide fifty percent? Do you do it in a tiered fashion? At the end of a certain period of time, do you terminate their employment?

I: Ok.

P: Do you allow them to remain on the payroll? These are all incentives.

I: Ok.

P: And incentives reflect an underlying set of values, which is used in the creation of the benefit. So, if I'm in California, and I get paid FMLA, in the absence of any communication, that's free time.

I: Yes.

P: Ok. So, is the incentive anything other than to use that to see my family?

I: I guess not, if…

P: The employer says nothing.

I: Yeah.

P: After all, the government itself said I'm entitled to this.

I: Yes.

P: So why am I not entitled to it? And you're saying I should ignore my entitlement.

I: I'm saying that there's a set of criteria that needs to be followed in order to get these entitled benefits.

P: Ok. Let's talk incentives here.

I: Ok.

P: So the criteria for FMLA, in particular, are that you go to see, that you have either an ongoing medical condition as evidenced by multiple visits to a doc, or treatment that's ongoing or hospitalization. Now, we're going to ignore the hospitalization piece.

I: Ok.

P: So, if you come to me in the clinic, and you, and you say "my back hurts," most back pain doesn't have an identifiable physical cause, ok?

I: OK.

P: Um, and you say "I would like you to prescribe me some drugs that I will take several times and to see you twice and thereby establish my FMLA claim," and I say to you "that's not really ethical and that reflects a set of values that I really can't support and I think is inconsistent with what Mayo is trying to promote"…

I: Mmhmm.

P: …then when you get your questionnaire from the Avatar, uh, organization asking that you rate me on my empathy and my willingness to be helpful…

I: Ok.

P: Right?

I: Yes.

P: Ok, now if I happen to be, um practice in Eau Claire, that's two percent of my pay.

I: Ok.

P: What's my incentive?

I: Your incentive to…being…

P: Do whatever you want.

I: Two percent of your pay.

P: Yes. Right. And, and if I don't do that, if I take the hit, the feedback I get is negative from the patient, negative from the organization, and negative from my spouse, who is wondering why we're short at the end of the month.

I: ok.

P: It's all about incentives. I used to think that when you're managing disability, you know, calling, having a nurse call up early, promptly, make contact with the patient, say "how can we help you? Are you getting the appropriate care? Um, what can we do to speed up your care?" Um, you know, are we, is, are the people who are taking care of you targeting the right thing?

I: Ok.

P: Are they focused on your bad knee when really it's your shoulder that's preventing you from doing your work every day, not so much the knee.

I: Ok.

P: Stuff like that. And there's no question that that can be valuable.

I: Mmhmm.

P: But I would, I- I – really, I have come to the conclusion that when it comes to limiting disability, and especially absenteeism at work, it's gotta be probably sixty to seventy percent benefits design.

I: Ok.

P: And it's incentives. And it's aligning those incentives all the way through. This is why, by the way, um, if you check out what's going on with large employers, many large employers are now bringing physicians at, at medical practices in house. They're either contracting with an organization to staff a clinic, or they're actually building their own clinic.

I: Ok.

P: And the reason is, it's not cheaper. Well not directly cheaper. The reason they're doing this is because they can begin to manage the approach taken by the docs. The docs, the docs don't want to just do whatever the patients want.

I: Yeah.

P: They want to do what makes medical sense and is appropriate. But, we're not actually free to do that very often, and, you know, certainly not in private practice – you need patients. Certainly not now at Mayo where most of, uh, most of the medical areas that are providing government care because we're being managed now on our patient experience. Oh well.

I: That's really interesting.

P: You hadn't heard that before?

I: No, that's a whole new, a whole new realm for me.

P: Yeah.

I: So this is very interesting. Um…all right…

P: So, think about communication.

I: Mmhmm.

P: How you communicate benefits, how you communicate why benefits exist, how you communicate changes in benefits, how you monitor – or do you even monitor? – the perception of employees about what benefits are for and how they've changed and so forth.

PART II

I: …People are dying to work with Mayo Clinic, and we want nothing to do with that.

P: Yep.

I: Because we have the ability to do it ourself.

P: Currently.

I: Yes, currently, we do. Um, in terms of disability management, I would like to…kind of take a five-hundred foot, five-hundred, five thousand foot overview, and just…do you, do you agree with our in-house format of it? Do you think we would be, it would be cost-efficient to outsource it? Do, what are your thoughts on…

P: Um…are we talking disability management or case management or what?

I: Disability management.

P: K.

I: Umm….Ideally…

P: So both absentee and presenteeism?

I: Yeah. So, ideally integrated disability management system.

P: I think that there's, um, given the array of incentives which are generally arrayed against you, um, I think a lot – you, are you familiar with the Spice Principles?

I: No, not at all.

P: There's a guy by the name of Allen Colledge um, and he's currently the, uh, let me turn this on. He's currently the, actually, you can look it up, because…

I: Oh, yeah, no problem…

P: …I don't think I'm on the, uh, uh the website here. Is it C-O-L-L-E-D-G-E? I think. Um, put in spice, S-P-I-C-E with a period after each letter, so S period, P period… I can send you a link, I have links back at the office.

I: Yes. We've got S.P.I.C.E. homepage. SPICE, Stanford University.

P: Yeah.

I: Try one more.

P: You could put in S.P.I.C.E. disability if you're looking for another keyword.

I: S.P.I.C.E. disable. Hmmm. Well, it doesn't auto-populate. So, uh…A Model for Reducing the Incidence and Costs?

P: Yes!

I: Ok.

P: [inaudible]…umm. Yes. That's it.

I: Ok.

P: Bookmark the, uh, bookmark that one.

I: Perfect.

P: Then you can look at it later.

I: Wonderful.

P: Umm, very briefly…

I: Ok.

P: Colledge, Colledge, uh, and, and actually there's another key reference, um, which you can just look up, you won't necessarily find it here. The American College of Occ. And Environmental Medicine, A.C.O.E.M., just A.C.O.E.M., uh, and then I would put in quotes preventing , uh, something like, is it needless or un- or work- or unnecessary work-related disability. It's a guidance document.

I: Ok.

P: And again, if you can't find it, I'll send it to you. It's, ah, probably five years old now. Uh, written by, um, Jennifer Christian, input from Colledge and a variety of other people.

I: Ok.

P: Um, it talks a lot about…the principles behind disability management.

I: Ok.

P: Ok?

I: Wonderful.

P: Now, what Colledge did, uh, he sort of started the ball rolling in some ways. Oh, there's one other reference I'll give you while you're on the subject. Are you familiar with Dame Black?

I: I have read that name, but I'm not…

P: All right. She was, she was, uh, she's a, uh, government official in Great Britain…

I: Ok.

P: …who has, uh – and Jane knows her, knows about her, or again I could send you a link – she published some very interest—the Brits are doing some very interesting work…

I: Mmhmm.

P: …uh, trying to manage, improve disability.

I: I read that!

P: Yeah. Uh, and she's, she came out with a report circa ninet-, circa two thousand and two, three four, something like that.

I: Ok.

P: Colledge's article came out in 1990.

I: Ok.

P: The first one. Anyway, what he did was he said, if we're interested in getting people back to work, and having them at work, after…how, how do you do that? And, who else, you know, if you're looking for a model, that you can test to see how well it works, where can you look? And

he decided to look in the military. And so he went, actually, he did a historical review back to the Peloponnesian War…

I: Ok.

P: …and said, you know, the challenge here is to take and injured soldier, patch him up, and get him back to the front line, 'cause, I mean, that's what the Generals need. Right?

I: Yep.

P: If you can patch up a soldier who's been shot, or whatever, and get him back to the front lines, you should probably be able to get a worker who's, you know, sprained his wrist, to get back to the job.

I: Yes.

P: What works? What doesn't work? What has been tried? What are the series of natural experiments? And that's what his paper is all about. And he concluded that there were some principles, S-P-I-C-E, simplicity, proximity, you can read 'em later…

I: Yeah.

P: …simplicity, proximity, immediacy, centrality of purpose, and expectation. And, um, he discusses all of these. I will simply suggest that, in my experience, the biggest obstacle is simplicity, uh, especially in the worker's comp. world, and centrality of purpose. And that is the Achilles heel in industry. The goals of all the different players – the patient, the injured worker, the, um, treating providers, the supervisor, the coworkers, the claims administrator, maybe for comp., especially for comp., probably, um, uh and other folks – they very rarely are truly aligned. So, for example, I'll give you a crude example. Um, the employee's hurt and wants to feel better. They, and their family would like them at work. So they're conflicted and somewhat stressed. The supervisor regards the patient, or the employee, as a pain in the ass and would just

as soon medical took care of it and he never came back again. And, as far as the supervisor is concerned, if the employee got long term disability, that's just fine, it ain't on his budget.

I: Ok.

P: The claims administrator wants to minimize the number of comp. claims so is interested in controverting, and of course if you controvert it, now you create all sorts of issues in terms of getting somebody medical care because nobody wants to pay for it. And, yes, I know there are supposed to be programs that get around that, and in my experience, they don't work. At least, not very well. Um, and the provider is simply interested in taking care of the person but would like to be paid, and now they can't bill it as comp., cause that won't work, and the insurance company is saying, no, it is work related, so they don't want to pay for it either, and of course the employee, him or herself has no money anyway. We don't have a centrality of purpose. You know, the other one is, the employee wants to come back to work, the doc., certainly if they come to an odd doc., we would like to speak to the employee, supervisor wants them back, the uh, comp. claims a manag- claims administrator realizes that the goal is to reduce the cost – net cost – total cost to the organization, not necessarily in their budget.

I: Mmhmm.

P: Now all of a sudden, things are aligned.

I: Mmhmm.

P: It's a very different scenario.

I: Yes.

P: So, S.P.I.C.E.

I: S.P.I.C.E.

P: And, pay attention to the centrality of purpose.

I: Ok.

P: Um, all right. With that all said, the question then is, should we outsource? What are the pros and cons?

I: Mmhmm.

P: And I've been through this discussion because while I was at my last job, I outsourced case management.

I: Ok.

P: Sort of. What we did was we outsourced responsibility for case management and arranged to have the vendor hire the people who were already doing it.

I: Ok.

P: Now there was a reason we did that. There was one- a couple of exceptions, but most of the staff transferred. Because it's all about values, and because it's about a sense of belonging and, and the cent- you know, the, the proximity of the workforce and feeling like you're part of the team, you're really, you owe it to your coworkers to be there and help manage the business and so forth. What it comes down to is do you have a relationship with anybody who can reinforce that and can encourage that and can, um, facilitate that connection and that emotional drive to come back to work. If you are a disembodied voice at the end of the phone who doesn't understand the corporate culture, doesn't know any of the names, doesn't have any sense of the, the values, or who doesn't have a clear sense of the values, or uh I don't know, the phrase is cultural milieu, I don't know if that means anything to you. It's hard.

I: Yeah.

P: On the other hand, if it's some- and, and certainly, if every time you call up on the phone you get a different voice, who cares?

I: Yeah.

P: If you get a call from your coworkers, just "hey Joe, how you doin?" or you get a call from your supervisor periodically to check in, right? That makes a big difference. You're still part of the group, you haven't been thrown to the side, they appear to want you back. Gee, you know, that's kinda nice.

I: Mmhmm.

P: That helps. That is more difficult to do if you have outsourced it to a telephonic organization that has no particular connection or knowledge or sense of who you are. If you have people that have been acculturated, who come into these roles, and are, you're consistently talking to one person, maybe, unless they're on vacation, but you know basically you have a relationship with somebody, you're far more likely to have an effective result. So, it should be possible to outsource to an organization where they agree that they're going to have a certain number of people who always are the people who are working with your folks.

I: Mmhmm.

P: And you can organize so that it's aligned so that all the environmental services people are always talking to, you know, Betty, and all the, um, surgical people are always talking to Harriet, and so forth, because the other thing that happens is the case management people learn the supervisors.

I: Mmhmm.

P: Because, bear in mind, the case managers don't control the job. It's all about the supervisors, right?

I: Yes.

P: Um, yeah, let me…can I, can I draw something on your…

I: Oh, absolutely.

P: …chart here for a minute? Just 'cause the…

I: Do you need a new sheet? Go ahead.

P: No…Ok. So, this is, this is a schematic about how we go about assessing fitness for duty, how disability management works. This is, this is my version.

I: Ok.

P: Um, what you have is you have employees who have certain capabilities and I generally categorize these physical, cognitive, emotional slash interpersonal. You have job demands. Same thing. Physical, cognitive, I mean, nobody, well, very few people at Mayo are hired because of their muscles. They're hired for their brains.

I: Mmhmm.

P: Right? So, what we do when we do disability management is we're monitoring the employees' capabilities. We're talking to the docs, we're saying, you know, what can they do? What can't they do? And then, presumably, we know what the jobs are, and this is where if you have a relationship with the supervisor. Supervisors control the jobs.

I: Mmhmm.

P: They define the jobs. They decide who does which job, right? So, you have an understanding of the job, maybe you've even gone and walked around and seen the job.

I: Mmhmm.

P: I mean, if you want to really make a connection, with a, with a hurt employee, you know, they tell you they're working in the basement of Franklin and you're saying oh my god, you know, it's hot as hell down there, they say yes it is. You have a connection.

I: Yes.

P: But on the other hand, you know, if you're sitting in the cities and you've never seen Franklin and you think it's a half dollar…

I: [Laughs]

P: Well, right?

I: Yeah, oh…

P: So you do a gap analysis, and the question is, can the employee's capabilities, do they exceed, meet or exceed the job demands? If the answer is no, then there's two things that need to happen. One is, we need to try to repair, rehabilitate, do functional restoration for the employee so that they are able to get better, and that means expediting medical care, getting appropriate medical care, getting attention to something that's, that's causing the gap that maybe nobody is paying attention to, whatever. That's a function of the case manager.

I: Ok.

P: The other thing that happens is, we need to propose an accommodation. In other words, a temporary or long term modification of the job. You know, if they get in a car wreck and they lose their leg, uh, and once, once they're all tuned up and they're as good as they are, um, you know, if that loss of mobility is a problem with the job, then they need an accommodating job. Right?

I: Mmhmm. Yes.

P: So, this is supervisor HR, with input from medical, this is provider and medical.

I: Ok.

P: And right here in the middle, continually monitoring this, this is your disability manager.

I: Ok.

P: Is this making sense?

I: Yes. It's very, very clear actually, thank you.

P: Ok. Good. So, that being the case, who, this person needs to have a sense of the employees capabilities, you can get that from the doc….

I: Yes.

P: …needs to have a sense of what resources are available to help restore function of the employee, which means they have to have a really good understanding of the benefits of the organization, how they work together, the different parts of the organization, what's EAP, how do you get access, is there child care available? – all those other things that get in the way of coming back to work. And then they also have to have a, a way of knowing what the job demands are, 'cause otherwise you can't do the analysis.

I: Mmhmm.

P: Right? And then they have to have the ability to work with supervisors to define what the accommodations are and, ultimately, if you cannot accommodate, repla…you know, move them.

I: Yes.

P: Long term disability or, or outsource or whatever. Or help place, I should say, or whatever. Right?

I: Yes.

P: You gonna do that with an outsourced organization at the end of a phone? I don't think so.

I: You'd be amazed at how many people do, but…

P: No, they don't do it, they try.

I: Yeah, they try…

P: But most of them actually don't even necessarily try to do this.

I: Mmhmm.

P: What they'll say is, um, a lot of them don't make a distinction between or make a distinguishing, excuse me, between a worker's comp. injury…

I: Mmmhmm.

P: …and a non-worker's comp. injury.

I: Ok.

P: So there's a number of, of companies out there that provide case, uh, at disability management for comp. only.

I: Ok.

P: Have you run into that?

I: Um, not so far. Do you have an example of a company, perhaps, off the top of your head? Otherwise I will go and look one up…or a few.

P: No, I, I, I don't, I don't have one in this neck of the woods. Ask..Jane probably will know.

I: Ok.

P: You can just ask her.

I: Yeah.

P: Umm, for a long, long list of reasons, um, that's a bad idea.

I: Ok.

P: Uh, starting with the fact that, um, if you look across most industry, uh, at the total disability picture, ten percent is compensable, ninety percent is not. So, if you're only managing comp… I think actually Mayo only manages comp….um, that's ten percent of the pie.

I: Ok.

P: You're throwing away ninety percent of your potential return. Now, I have to tell you, when it comes to specifically to Mayo, we don't do what I call case management.

I: Ok.

P: We do case monitoring.

I: Case monitor…Ok.

P: So, um, and what I mean by that, I'm talking about current state.

I: Ok.

P: What I mean by that is, when I first came here, um, wh- and let me digress for a minute- you need, when somebody says to me, um "I do case management," I have learned that it is critical that I immediately ask them to define their term.

I: Ok.

P: Case management means radically different things to different people.

I: Yes.

P: So, somebody says "I do case management" – that's great, what does that mean? Tell me more. And, if you fail to do that, I can't tell you the number of times I've been led down the garden path. Which is why I , I don't do that anymore. Ok, um, we don't do, what this is what I would call case management.

I: Ok.

P: That's my definition of case management. We don't do that. When I first started working here, I, um, ended up seeing somebody and they had a podiatry appointment, it was six weeks out. So I picked up the phone and I called the case manager, eh, the team, uh, and I said to them, you know, this guy's got six weeks out, can you speed this up for me, please, and they said "that's not our job."

I: Oh, ok.

P: It's kinda like, really? It's not.

I: Interesting.

P: It's not. The other thing about the current state, while we're on the subject of the current state, um, so that's why I say they're not doing case management; they're not assessing that gap.

I: Mmhmm.

P: Umm. There are two teams. Right? Orange and blue.

I: Yes.

P: If you are a member of the orange team and you call up, who will you talk to? You have no clue.

I: No.

P: Any member of the team, right?

I: I don't.

P: You know, same for blue.

I: Mmhmm.

P: So, your relationship is with who?

I: A color.

P: Right. Ok.

I: [Laughs]

P: Colors aren't empathetic.

I: No…

P: Well I suppose orange is a little more empathetic than cool blue, but doesn't work for me.

I: Ok. So, this is what you would ultimately like to see here, with a management, not a monitoring.

P: Correct. And I, I think, one of the, um, how are we doing for time? Oooh.

I: Are we over our…?

P: No, not yet. Um, but one of the things, one of, one of the reasons that I was particularly interested in trying to be helpful here…

I: Mmhmm.

P: …was because this piece down here, the accommodation piece…

I: Mmhmm.

P: …is actually quite tricky. And…

I: I'm learning that.

P: Yeah. If it's done well, it's enormously helpful. But, um, especially when you, one of the common things we like to do is re-deploy people within the organization. In order of costs…

I: Mmhmm.

P: …the least expensive outcome from any absence is to return to the original job.

I: Mmhmm.

P: The next is to return to the original job with an accommodation. The next is to return to the original organization. The next is to return to another organization within Mayo. The next is to return to work somewhere, anywhere…

I: Mmhmm.

P: …in Rochester, anywhere in the country. And the most expensive is to go long-term disability. So, trying to re-deploy people, this is part of the proximity piece that you'll read about.

I: Yes.

P: Um, this is the return to work group.

I: Mmhmm.

P: They do it better than anybody I've seen. They work across boundaries, umm, in ways that I would have loved to have done in my last job.

I: Mmhmm.

P: Just, couldn't make it happen. Some of that was culture.

I: Ok.

P: Um, they've, they, are, they manage the…it just works. So if we could build the rest of this piece, especially this piece over here…

I: Mmhmm.

P: Then you've got at least three quarters of the system. And if we can get HR to get their act together a little bit, especially around the MC 61 and the job demands, you've got the whole package. Mayo's pretty close.

I: Mmhmm.

P: And I think it would be an enormous competitive advantage for Mayo. I really do.

I: Wonderful.

P: So, that's why. So, uh, to spend the last few minutes, why am I involved with this at all? Um, I came here to do safety. I did not come here to do occupational medicine. I got dragged into it and, after I'd been here for about six months, I had a conversation with my chair, and he, uh, asked me to take on a project to understand what the opportunities were to improve occupational health services for employees at Mayo. So I interviewed about forty people, all over the map. Everybody, multiple disciplines, multiple levels, uh, and came to the conclusion that, among other things, we did case monitoring, not management, and that the way Mayo had structured its monitoring operation, um, was impeding information flow. So, in order for this to work, the case manager needs to be able to talk to supervisor, needs to be able to talk to the return to work

people. And, that wasn't happening, and it wasn't happening because of assumptions that were being made about legalities and how things needed to be organized and run. So, I put together a, uh, an SBAR, which went up to, uh, Mike Harper, and it came back with a charge saying please redesign, uh, disability management for Mayo. So I have been working, worked for about a year with a group of people, including Jane, and we put together a process, which I presume she showed you.

I: Yes.

P: Um, and, as we were in the process of implementing this, um, HR was charged with putting together an assessment of the processes, and they decided to go off in a different direction.

I: Ok.

P: That different direction is fundamentally incompatible with what we've just discussed.

I: Ok.

P: So, at this point, there are two proposals on the table, and there is discussion about how we, A) I'm not sure you can resolve the two and merge them, I think it's a matter of you pick this road or that road.

I: Ok.

P: And those discussions are ongoing at this time.

I: Ok.

P: And that's kinda where it stands.

I: Ok. Very interesting. Very interesting. Well, you've been incredibly helpful.

P: Good.

I: Thank you so much for meeting with me. Um…yeah. This has been wonderful.

P: I think, I think that, um, when it comes down to communication, I would encourage you to look at, at the Colledge article.

I: Ok.

P: And, say, you know, as you think about each of the items, take if you were to assume for the purposes of discussion, that Colledge has it right…

I: Mmhmm.

P: …and you need to serve, you know, Simplicity, Proximity, blah blah blah blah, who do you, for each of those principles, who do you have to talk to?

I: Mmhmm.

P: What do they have to understand and how would you communicate, within their interests…

I: Mmhmm.

P: …because the interest of the supervisor, the interest of the claims people, and the interests the docs, and the interests of the employee are all different. So, as you do your communications, you're clearly segmented, right? We don't do a good job of communication here. And everybody…

I: We have a few silos.

P: Sorry?

I: We have a few silos.

P: Well, it's not even that. Um, we don't communicate within the silos. I mean, I can, if you have a silo, I can communicate to your silo.

I: Mmhmm.

P: What I do, is I have a tri-fold that is targeted to the, the injured employee silo, and when you are injured and I have my first contact with you, I mail you a tri-fold and it says "Hi. Here's who

we are, here's what we believe, here's what we believe you should be believing, because this is how we're going to work together to keep you employed, which is a good thing."

I: Mmhmm.

P: Right? And so, I would target you.

I: Mmhmm.

P: The supervisor, I would go to the supervisor and say "you now have an injured employee. Hi. Here's who we are, here's what we believe, um, you now have an injured employee, here's what you can do minimize your labor cost, to sever the organization, to be a good supervisor, and to get this guy back as fast as you can. First of all, call him, talk to him, know it's not harassment." Common misunderstanding.

I: Yeah.

P: Um, and so forth and so on. So that's the supervisor, and for the doc, it's kinda like "Hi. We're here to help. We're just going to be periodically touching base, here's why. Here's why we really don't think it's fair for you to charge us $15 to fill out our brief questionnaire, and here's why we won't be going to you very often because, while we would love to, we respect your time and the fact you aint getting paid for this." So you could target, right?

I: Mmhmm.

P: And, there's a common goal…

I: Yes.

P: …but the actual communications are all different and they're segmented by audience, and they have to be respectful of the values and the norms for each of these silos. It doesn't worry me that there's silos.

I: No.

P: I mean, that's another discussion.

I: Yes.

P: Ok.

I: All right. Wonderful.

P: All right. So, um, where do you go from here?

I: I process, I continue reading, I'm going to start looking at some numbers soon…[laughs].

P: Good luck.

I: Thank you. I, when I took this on…

P: Oh, it's difficult to get numbers.

I: It is.

P: Especially from benefits.

I: Yes. It is. Um…

P: I mean, if the cost's very depending on outcome…

I: Mmhmm.

P: …wouldn't it be nice to know how many of which outcomes we had?

I: Yes.

P: Good luck.

I: It would be wonderful. It would be great to know.

P: Good luck.

I: Yes, that's what Brandon, my supervisor, told me as well, so…

P: So, as you think about this, have you done any quality work?

I: Uh, no, not yet. I am…

P: If you were trying to manage a process…

I: Mmhmm.

P: In quality terms, what you do is you measure the, the process outcomes…

I: Mmhmm.

P: …you modify something and you see if it gets better or worse, and if it gets, if it gets worse you go back to what you were doing. Try something else, right?

I: Mmhmm.

P: If it gets better, then you see if you can tweak it some other way. So, if we want to improve our processes, we need to be able to measure our outcomes.

I: Mmhmm.

P: You've just told me you can't do that.

I: For all of our…for…benefits? I'm working on getting numbers. I didn't say I couldn't get them.

P: Oh, ok, well if you do, would you please…

I: I just said I…

P: …please let me know what they are.

I: Ok. Yes.

P: Because I've tried for a year.

I: Ok.

P: And the benefits people, um, said that they didn't think that was a value-adding thing for them to bother to give us.

I: Ok.

P: Now, they've been asked…

I: Would this…

P: …well keep asking, maybe you'll be lucky.

I: Would this be something, just, off the cuff, would…are these numbers that they already have or are these numbers that they would have to…

P: They'd have to run their databases to find.

I: …run their…ok.

P: I don't think they track them, because Mayo doesn't manage benefits in a way that's similar to anybody else I've ever met.

I: Yes…I'm coming to realize that.

P: Right. So, for example, there's some other things, too. If you're running a process, you're trying to do anything …before you can improve a process…

I: Mmhmm.

P: …you have to have a process, and if your process is inconsistent from day to day, you can make a change, but how would you ever know if it made any difference?

I: Mmhmm.

P: Right?

I: Yes.

P: So you need what's called Standard Work.

I: Yeah.

P: You need a standard process, which is why we spent a year documenting processes. Mayo doesn't have a reasonable accommodations process. In other words, if I ask for an accommodation, or I recommend an accommodation, and the supervisors having a really bad day, 'cause it's Monday, and they can say no, there's no appeal, there's no review, there's no subsequent…a way of ensuring that that refusal was anything other than arbitrary and capricious.

I: Ok.

P: Ok? There should be.

I: Yes.

P: We don't have that. Um, if you want to know what are the, what, what, under what circumstances is someone eligible to continue absence under STD, uh, the answer right now is, um, FMLA. See, I have a problem with that. When somebody goes out of, out of work, the question that you ask initially is "are they entitled to receive short term disability benefits?" That's the question. That depends upon your benefits design. It's not infrequent that, at the end of whatever their benefit eligibility is, all of a sudden, they have what I used to call a miracle cure, and they're ready to come back and they've got their doc on the outside who's no doubt conscious of his Avatar score, who says, "well, ok, return to work, no restrictions." The question at that point is different. The question is- there's two: Is it safe for this individual to return to work? And, secondly, can Mayo deny this person return to employment? Very different question.

I: Yes.

P: So, at what point in the process do we change from "they are eligible to receive STD" to "we can deny them employment?"

I: …well…

P: It's gotta occur somewhere.

I: Somewhere, it does.

P: If you don't, then what happens is people go out and get paid, they get paid, they get paid, miracle cure, and they have an eleventh hour return to work. And I promise you the supervisor

will be royally pissed. So, the benefits people, I would hope, I asked "how many eleventh hour returns to works do we have?" and we don't know.

I: Ok.

P: I said, "How many absences do we have over the course of a year?" and the answer is "I don't know." Now, what we did was we went to comp. Comp. knows.

I: Mmhmm.

P: So, using the nine, ninety-ten rule, you can estimate, add another zero to the compensability absences, and that's a rough approximation of your total absence.

I: Ok.

P: Right?

I: Yes. Maybe.

P: Maybe.

I: I'll have to go back and do some more research in this area.

P: Well, but this is, what is the ratio of comp. absence to non-comp. absence.

I: Ok.

P: And, I have the benefit of experience which you don't have, I, I understand that. I'll simply suggest that you can add a zero to comp. and you will have a rough approximation of your total absences.

I: Ok.

P: That's what I've done. So, when you're trying to get numbers, sometimes all you have is a surrogate and a crude approximation.

I: All right.

P: But, anyway, good luck.

I: Thank you.

P: And I would be interested in what you finally come up with.

I: I will gladly send it to you when I am all done with this bear.

P: Ok.

I: Thank you very much for meeting with me, I really appreciate it.

P: You're welcome.

I: You've been incredibly helpful.

P: Fine, good. And, uh, um, give my regards to Jane.

I: Will do.

P: And, uh, she should be able to be extremely helpful as well.

I: She, yes, she is my go-to…

P: You were going to talk to Greg Couser?

I: I did talk to Greg Couser.

P: Good.

I: Yes.

P: Ok. Mental health is a whole other discussion.

I: It is. Thank you so much, I appreciate it.

P: Take care, buh-bye.

APPENDIX 6

Disability and Communication Focus Group Transcript

May 16, 2014

Hello, my name is Kyleen and I work as an operations coordinator in RCS here at Mayo. Additionally, I am also finishing up my graduate studies at the University of Minnesota-Twin Cities. Thank you all for coming today, we will be here for around an hour.

I will have my phone set to record during the discussion so I can make sure that I don't miss any comments and create an accurate transcript. This discussion will remain completely anonymous and no one will be referred by name in my paper.

Before we begin, let me suggest some things that will make our discussion more productive. Please speak up—only one person should talk at a time. You are not required to answer all or any questions for that matter. If you don't want to answer just say so. There are no wrong answers. Different points of view are encouraged—we would like to avoid the spiral of silence. Both positive and negative comments are encouraged. It is important for me to hear a variety of thoughts and opinions as you all have different experiences.

Off the record:

1. Please introduce yourself and tell your role at Mayo Clinic and very briefly what you enjoy about working here.

Begin audio recording:

2. What kind of activities does Mayo Clinic or your specific work areas do to promote the health of its workers? What would you like them to do?
3. Does everyone have a general idea of what Disability Management encompasses?
4. If you have a questions regarding Mayo Clinic's Disability Management do you as an employee know where to look for answers? Where or who would to turn to?
5. Is it easy to talk about Disability Management in the workplace? Do you think employees are afraid to discuss they utilize disability services? What can be done to make this better?
6. Should Disability Management education courses be offered? What kind of resources do you think would be the most beneficial?

I would like to switch gears slightly and discuss communication at Mayo

7. We are discussing formal and informal communication at Mayo. How do you receive most of your formal information and how do you receive the informal information or from whom?
    a. So you are saying that your communication channels are:
    b. And your communication tools are:

8. Give me some positives and negatives of your current internal communication channels.

9. What forms of communications do you see as beneficial in getting your job done more efficiently and effectively?
10. What methods of communications do you think are beneficial for employees and faculty to stay in touch with what is happening on the Mayo campus and its surrounding community?
    a. Enterprise wide?
11. Do you feel that you are getting what you need, internal communications wise, from the Mayo Clinic?
12. If you were in charge of the communication to employees and faculty at the Mayo, what kind of changes would you make?

Thank you.

Transcript

Were are going to start with talking about Disability Management a broad, 5,000 foot overview, type perspective. You don't have to know anything about DM.

1. *What does Mayo or does your work area do to promote the health of its EEs? If you cannot think of anything, what is something you would like your area to do?*

H: In HRIS we have implemented the option to work from home which helps a lot of EEs, not only with work/life balance but if you do have a disability, you may feel more comfortable working from home. A few of our colleagues have walking work stations like to use in stead, they also are very open to different chair types, standing work stations, things like that.

G: I've never had a problem getting my desk changed or getting a new keyboard or anything. It's always like "yes, absolutely, what ever you need." Then we are also always encouraged to get up and take a walk in the afternoon and get away from your desk for a while just to clear your head. We have a health and wellness committee that gives us a heads up on a lot of different things going on around to help us stay a little healthier.

D: I agree with [Participant G] I have had my desk examined and altered because I have a height issue and they've always been very willing to accommodate to help make this easier.

A: Our department is also implementing…we are doing a pilot project right now… on telework ad hoc for several years and now we're actually working on a pilot project to telework on a scheduled basis and we've been working on that for a few months now. I really enjoy that, the opportunity to do that and its really helping a lot of us…more focused and the provided opportunity is really nice.

2. *Does anyone have an idea of DM? If you had to give a definition of DM, could you do it?*

C: Well if you want me to define it in one sentence I can't do it, but I can kind of paraphrase and I think we need to do a better job of this which we don't quite yet have a handle on…we're working on it. Working with the people that I work with in the clinical area, there's not just the physical health and wellness but there is also the mental health and wellness, it's the life

stressors it's the work life balance issues. I think that's what really wears on a lot of our staff and again my perspective is the clinical setting, just the constant grind that they're involved with, you know they're probably somewhat active, walking around and stuff, they're moving the mobility is there but its just the mental health perspective that I am concerned with and we're seeing more of those in the work that we deal with and I feel [DM] is a more holistic approach to the individual's health and wellness rather than just the physical approach.

PAUSE

Mayo Clinic's Definition:

"…the proactive, employee-centered process of coordinating the activities of employees, management, claims, health care providers, and return-to-work coordinators to reduce the impact of injury, disability or disease on a worker's capacity to successfully perform his or her job" (Recovery and Claims Services, Mayo Clinic).

3. *If you had questions regarding Mayo's DM system, would you know where to look or who would all in order to find answers?*

D: I think the Service Center would be a good place to start.

I: (thumbs up) That's good to hear!

D: I would assume they would direct you to the right place. The EE assistance program. If it's dealing with a work situation, it might be…we know (acknowledges participant F) this because we deal with this… the Return to Work [program]. Talk to your supervisor.

H: I probably would also go to the "For You" page. I don't know if there is a link out there but that is where I would think to go automatically.

B: There is a lot of knowledge out on the page.

Group: Nods and laughs in agreement.

H: We're working on redesigning that page there is something like 242 links on it.

Group: (Awed).

4. *Do you think that DM is something that is easy to talk about in the workplace?*

C: I would say that from my perspective it is not, its not easy because there are a lot of moving parts and I think a lot supervisors aren't fully aware of how it all works together. They sometimes maybe confuse RTWs role or occupational health's, or HR role differently… and I think from working behind the scenes there is probably some work to be done about integrating these components, and I'll share from HR's perspective…but I think it goes deeper than just managing health and wellness in the work place, but also looking at job design… you know

suitable for somebody for a 20 year career, or will they have to look at how will it affect someone along the way. We have a lot of high tenured ee's who have been here for quite sometime and that is what we're seeing is that your bodies just break down from the constant work that it is. The other part could be, more career counseling in place, talking to that clinical provider and asking them "is this the type of role you see yourself in in 15 years, 20 years" and those are hard discussions to have because you are asking someone to do is be realistic about their future...and you know everyone is human and yeah our bodies get older and we can't necessarily do all those same things and yeah I think there is opportunity to go even deeper. I try and align it to, like what we're trying to do with medical care…we're not trying to just treat people in crisis but go beyond that and treat them to prevent crisis…and if we look at it that way you probably get a better, or more proactive approach. And this is my perspective of about 10 years in HR. These leave management issues just compound and they are just getting much more prevalent because we have an aging work force, less resources, more sick patients with multiple conditions and that's just the reality.

E: Do you think it's easier to spitball and brainstorm ideas than it is to implement ideas, I mean that kind of goes for anything.

C: yeah I think people have great ideas but the implementation is tricky because there are different stakeholders and they have different objectives you know, I don't want to say agendas but different priorities with the way they are looking at the world. And I think that it…. You've got to translate language across different areas. You know HR people have to understand where

Claims is coming from and Claims has to understand where Occ. Health is coming from and so forth and we just need to get these parties together to get on the same page.

I: I don't think that, and you touched on this, but I don't think that this is easy to talk about because like a lot of EE issues it is emotionally charged, and it's just, it becomes, and then you have like with a lot of things you have someone who has had a good or bad experience, or knows someone, a supervisor knows another supervisor or an employee who knows another employee whose had a negative experience and then that kind of colors the whole conversation.

E: True true

Any other thoughts?

Do you think that EEs are perhaps afraid to talk about certain aspects…or not necessarily afraid but unwilling to talk about DM because it either doesn't affect them or simply because it is a hard topic?

I: I think it's hard and I think there is some aspect of just not even being aware. Like "that's not going to happen to me, that not, whatever" I mean if you never use a particular benefit you have no clue that it even exists.

Alicia: And I think going along with what she [participant I] was saying before is even within the different work departments, there are different ways that supervisors supervise and how they utilize procedures and interpret.

A: I agree and I think each department has a different budget and different things they offer, I mean one department might offer different things, sit stand desks, all these options while other departments the budget's a little tighter, they have other focuses, so that's not an option so I think it creates more difficult conversations because that might not be allowed in your department or they might not offer it to everyone the same so I think that that makes it a little bit fuzzy.

C: The reality is that a lot of these supervisors are managing to a tighter budget, tighter staffing plan, so when an EE has a situation the first things they worry about is "what's going to happen to me, what's going to happen to my job…" because it's not widely talked about and those options might not be known. I actually had a meeting this morning with several nurse managers about how they navigate these situations and get communication to their employees about leave management and I think its going to be beneficial.

5. *Do you think it would be beneficial, in addition to Benefits University, to add more a total overview course or information packet, or something geared toward EEs and supervisors that is solely focused on Disability Management?*

B: I think a packet would be nice because not all work areas have the flexibility to take off to attend classes so that those workers could also have something to reference. If you're not using the benefit you don't know exactly what it is until you need it and at that point, it's overwhelming to learn about it.

I: Yeah with everything else going on…

E: They do have a little bit of an intro to everything at New Employee Orientation (NEO) but Disability Management obviously is not one of them at all, but you are given some idea as to…it's not an in-depth discussion but…

C: And there is probably some conflict with that because then it's like "hey welcome to your new job, let's talk about your disability…"

Group: Laughter

C: Leave Management Stuff is probably tapered a little but we could probably go more in depth about if you have these issues here are the resources, and here is essentially how we handle that as whole.

E: But until I began working in this Department, I had no idea Mayo Clinic offered these services to their employees.

A: Well and if you learned about it at New Employee Orientation, the services have changed by the time you've been here for five years…

I: And With orientation, its funny you bring that up because I used to do the benefits presentation at orientation. We would lead into time off with "ok, it's your first day and you're ready to take time off?" I mean we would make it a joke…but um the balance in providing…especially since it's gone down to one day…instead of two full days, it's now one day and then you get benefits the second day. They really crunched it down…which I think is good but we focus on the things the employee needs to make a decision on and so we gloss over all this other stuff and then it changes… I mean we barely talk about the pension plan…"You don't have to do anything but you do have to enroll in medical and dental so there's all this… the other thing is toolkits have been big…so a 10 minute video and materials, so then it's there when you have 10 minutes, crunching it down for people who can't get away. The video archives for the benefits university have been huge because people can maybe get away but they may go on…I know that has been really super.

C: Are you guys tracking hits?

I: Yeah, and they've started an on-line survey for the benefits university and the comments…the feedback has been really really good and they actually look at all of it.

E: I think the last BU I went to all 3 enterprise sites there were a total of maybe 20 people there in person and I think those people didn't know that they could just stream it on-line.

C: and they left at the break right?!!?

Group: (Laughter)

I: Oh wait I can be watching this [from my desk]??

6. *Are there any resources that you think could be potentially beneficial that I didn't mention here?*

I: the only other thing that I would say, and I know Manny and Jenna know this because we talk about it, there is a limitation to the amount of information you can find when you are not on campus.

Group: [general agreement]

I: So when I have time to read it, maybe it's when I am at home or I'm thinking about it in the evening or over the weekend, I can't to what I need and so in HR we are working to get stuff outside the firewall…and that's a huge project…or that's something that maybe your spouse, if you're in the situation and the spouse needs some information.

H: So an EE portal.

D: More stuff on Mayoemployees.org site?

I: Yeah, so stuff is available because it's not just the EE that needs it.

C: I think there is also a system, I mean I have tried to view videos from my phone or iPhone and you can't do it….[because of] Silverlight or something but perhaps having more information on like a YouTube or something would be beneficial.

I: yeah.

E: And they are working on that end as well, with the global applications. My biggest…well the good thing about the Mayo intranet site is the redundancy they put in place on multiple pages to access link, whether it's the "For You" page or six pages deep there is a lot of redundancy built in, the problem is the algorithm that they use for the search function doesn't pull up what you're looking for…I mean its takes a phone call to find what you're looking for because if you don't hit those certain keywords you're not going to find what you're looking for.

C: yeah, and once it gets tough like the first or second time you stop and then just find another resource.

7. *Ok let's switch gears here and start discussing communication here at the clinic. When discussing formal and informal forms of communication at Mayo, how to you receive information? (Internal Communication).*

B: Email like crazy.

Group: [general agreement]

D: especially with secure email now.

G: It's just the fast way to get information and a lot of outside people too are starting to use secure systems and are having easier times signing into our secure program so their ready to email you stuff and get your email back than they used to do too.

A: For minor things, and I am using it for work stuff too, but if I just have a quick question I am using office communicator constantly. I know, just like everyone else, that I have so many emails that if I need to find something right away it might take me a while to get to it…so its nice sometimes to just ping someone and say" do you have a second, or do you have a second for a quick call" and then they'll tell me if their available.

I: Or "hey, I am going to stop by…"

C: I know Yammer is a social media site within the organization…I don't know….I think that they are trying to reinvigorate and there is some information sharing in that platform as well.

G: That is something that I feel like we could do a better job of utilizing, I don't really know what I am doing on there but I feel like there are a lot of things where we are having a conversation by email and this is super annoying to have this giant email string…it would be nice to have one discussion group. So how do you get everyone in the office to buy into it and to use it? SO that would be nice if we could figure that out.

A: The Legal Department uses a lot of private Yammer groups. We have different practice groups on different areas of law and they each have their own private Yammer group so we share a lot of information that way. Um…webinars, other CLE things you know questions kind of for the entire group across all the sites… you know "has anyone worked on this, has anyone heard of this project, who's handling this" so we use that. The paralegals have their own too…so we use that quite a bit but…the only thing I would say we are struggling with would be, it's great to have conversation but sometimes people want to share documents it's great for blogging but it's not the best for sharing…the legal department is trying to figure out the best or a better way to figure stuff out…and figure out a way to communicate better with some Yammer, maybe some SharePoint, just using OC…there are so many opportunities but trying to figure out what is the best fit for how your communicating.

H: I think for projects, SharePoint is awesome.

A: That is what we have found too, and are leaning toward.

A: That way you have one version of every document out there.

I: The documents portion of SharePoint combined with the Conversation aspect of Yammer would be great.

C: So yeah, Yammer, there is a mobile app. for it so you can be mobile with it and just like with texts… you get a text and you can just respond. You can be a lot more flexible with communication and you don't have to worry about emails and that sort of thing. SharePoint is good for comparing documents but it's not a very good mobile platform.

8. *So I am hearing: Email, SharePoint, Office Communicator, Yammer. Give me some positives and negatives surrounding your current internal communication channels.*

H: Well like I said with email, you've got giant strings and if someone replies and you miss each other you might need to repeat things you've said and repeat questions…you know if you go off this way and then this way and different directions in the conversation and it just piles up.

A: And the abundance of emails that are out there its hard to make it effective communication for timeliness.

D: it can make your files very complicated.

E: Communicator is one more thing you're checking on your computer as well…it's another thing that is flashing at you, for your attention.

A: I do like, part of communicator, if you are having a discussion with somebody and it turns into something more that you want to save, you can do a 'file-save as' and save it to your email conversation history. I've done that a lot where I'm like "oh I need to save this to my file…it ended up as more than I was planning." So that's a good option to.

A: Yeah, so you don't close the window and then forget the entire conversation you just had…you have it saved to your email.

D: I also find that with office communicator is very beneficial for simple questions rather than having to walk across the office to ask someone.

A: Well and as Mayo is moving more toward teleworking the face to face interactions are a lot less to the use of office communicator and Yammer and email and other options is more important.

I: A lot of the employee service reps that you talk to when you call are at home…actually all of them are. They use a group chat so it just sits open all the time and it's like when you used to just pop your head over the cube is kind of what we said and its this on-going conversation "has anybody had…" and its funny what comes out in those… "Ok we're getting a lot of payroll calls today, what happened…you know, paychecks aren't available on Mayoemployees.org" that sort of thing. So it's very timely and it is trying to simulate what we have in the office at home.

9. *Do you think we are losing anything in not utilizing face-to-face communication anymore, or using it less frequently?*

D: I do think it is important to be able to have the person-to-person communication.

G: I think it's a give and take because like with the office communicator… if you are getting a lot of questions you can respond to that on your time and it's a quick response back and forth and it's not bothering your co-workers when we're all trying to do more work with less time or whatever…but at the same time if you have something a little more difficult to talk about to get facial feedback and body language and you are able to have a more "crucial conversation" with someone.

A: Yeah, or more extensive conversations…you know if it's a big project or something you need to be able to talk back and forth and sometimes messaging all the time or email… can be lost in translation…

G: Yeah, you don't always interpret all the nuances…

I: Yeah with all electronic communication you lose that

H: Well even with…In HRIS we have hired a lot of people on the coasts…east coast/west coast and just training them in…even if you are on the phone with them you can't see their face so if

they say “yes” you can tell if they are saying “yes [affirmative confident yes] or “yeeeeessss? [quizzical confused]. You can read body language.

C: Yeah you can’t read body language!

H: Yeah, so we’ve actually gone to webcam which means you always have to have your hair done but it is good for picking up those cues.

A: Yeah, we’ve seen more of that too especially with the attorneys communicating with the video along with office communicator too with other offsite too just if its one on one communications just so they can get more face to face interaction.

A: I mean you might be able to field off more conflicts….if the other person is feeling some sort of anger you might be able to see how that conversation is going and then field the conversation accordingly.

H: Or retention. Sometimes people don’t want to communicate that they are frustrated or bored or don’t get something...if they’ve asked you a couple of times already...they might just move on and start looking for another job instead of sticking with it.

C: related to Disability though, I think….I don’t know if you are trying to tie the communication in to that but there is probably some use for more electronic means but definitely the face to face when you get to more sensitive topics or content…I think there is… you know…certainly getting

information or educating folks doesn't necessarily need to be face to face it can be more remote or electronic but as you start getting into more specific situations…In my experience definitely face to face…there is more opportunities for them to ask questions, to read body language, are they tense or upset, or frustrated you can kind of speak to those nuances and then help them feel a little more comfortable.

G: I suppose with a sensitive topic you'd rather have that in person than in an electronic form…I don't know

A: I thinking writing it sometimes is the easiest go to but…

I: It is subject to interpretation.

Group: Right, [agrees].

10. Do you think it would be beneficial for us to utilize live video chat?

B: I think on more broad subjects it might be handy but I know that I get calls and…well I can handle this part of it, it I'm going to need to get you here to handle this part of it, and then they are probably going to need to get you here to handle that part of it so…so I think over a broad subject it would be helpful but otherwise they are just going to get frustrated when you are transferring them on the phone multiple times.

11. *What methods of communications do you think are beneficial for employees and faculty to stay in touch with what is happening on the Mayo campus and its surrounding community? Enterprise wide?*

G: I feel like our news center on the Mayo Intranet does a really good job of covering big events… at all the places that are going on. If there is a big event in Florida that's important its up on that page or you know like the weekly newsletter or the *This Week at Mayo* that comes out has a good range of topics and there are a lot of community interest pieces too where there is somebody in a small town who had their life saved because they went to Mayo Clinic and so you get to hear all the different pieces and I think they do a good job with that.

B: And if you live in the small communities we get a brochure or pamphlet *The Source* from the clinic that is in our area and it will include our clinic as well as a few Rochester articles as well.

12. *Do you feel you are getting what you need Do you feel that you are getting what you need, internal communications wise, from the Mayo Clinic?*

H: I kind of feel like I don't know what I don't know. So right now I think I'm getting what I need until I hear people talk about different programs or different things going on…Then its like "whoa…I didn't know this that was going."

I: I think there is a balance between push and pull. Ya know, *This Week at Mayo Clinic*, I get it and I read it because it pops into my mailbox, I read *In the Loop* because it pops into my mailbox. If I am looking for an answer to a specific question I go to the "For You" page…I pull the information in but like Participant H said, I don't know what I don't know.

C: Well and I think about, like Google News has an option where you can plug in search terms. So I plug in Mayo Clinic and so anytime there is a news story on Mayo Clinic it pushes out whenever I want it…like once a week or every other day…if we had something like that where that information from inside… you could put in…"hey I'm interested in Congestive Heart Research or Disability Management" and every time that comes up it pushes to you.

I: That's a really good idea.

Group: [Agrees]

I: You should share that with public affairs.

C: Yeah…I'm full of all kinds of crazy ideas….but then I have to do all the work.

G: Yeah, as soon as you suggest something…"Oh you'd be great at that!"

D: But I think thinking about different ways that will work for us would help us to communicate better and work better.

13. *If you were in charge of the communication to employees and faculty at the Mayo, what kind of changes would you make?*

A: I think, and I am not sure if I am delving into something different but I think there is general communication for the masses and then there is the lack of communication between the sites on…there are a lot of communication issues within Mayo as a whole. In general I think to the employees in pushing out certain articles and certain events I think they do a good job… you know and in community outreach but in general for communication between departments…I mean I know we are working towards a centralization which is supposed to be helping with that

but I see it all the time where one site is doing something and they've been pushing it for years and another site is just starting it and it's a brand new thing but they are working with the same company and there is no communication. Really overall it is kind of a mess on how we communicate on a lot of different issues. I do think it depends on what level of communication we are talking about…I think that for general employees and in general resources, and the great articles, and benefits [university] stuff I think its great but behind the scenes then at the initiatives of the different divisions and the different sites I think it's a whole different ballgame.

I: There are definitely silos.

G: Systems and procedures communication isn't as good as just general information.

A: Well and it's really surprising that every...and I've seen this more and more…how many projects that every individual division and department is doing on their own even though, I mean I don't even know how many…I mean I know there are committees everywhere but the oversight is mind boggling…the lack of communication between departments. I think there is a lot of that kind of communication that we aren't real good at. I think we are working our way toward that with, you know, the centralization of the EMR (Electronic Medical Records) and centralization of departments, like I think the revenue cycle has been a good example of gradually working toward the "regardless of what site you're at this is the division chair…

I: More of a shared services model.

A: Exactly

D: and I think that's been kind of, from the start even since I been here, touchy with some of the health sites because you want them to feel like their own but then you want everything to be the

same but its kind of been a balancing act of well “ok what would you like us to help you with?” I know I’ve experienced this with the general liability work that I do, we asked them for all their procedures, they weren’t necessarily opposed [face expression suggests otherwise] and then said “ok if you need help with this we’ll guide you and let you know any inefficiencies we can help with, but it’s a matter of still letting them do things on their own and not feeling like we are just taking everything over.

I: Yeah, they are dealing with a lot of loss of identity as a site or a region.

A: I think we have so many policies, I mean it’s great that we have policies but people have no idea that there is policy on that.

I: or where to find it if there is one….

H: Or what to call it…

A: Yes, I am literally every day directing someone to a policy that they have never heard of that has been here for ten years and I explain “No, you should have been doing this all along…” and that is just one person? Now how many other thousands of people don’t know that they’re supposed to be doing this, its that communication that is so hard for us and is lacking.

C: I also think that there are a lot of “Best Practices” within our site and institution that it would be great to have a platform where divisions and departments can share their “best practices” and say “hey we’re doing kind of the same thing, why don’t we partner up and do this thing together.”

I: A shared knowledge base almost.

C: but, I support the Department of Radiology and we've got a lot of projects going on and the question I always ask is "Who else is doing this, or who can we partner with to do this?" It seems like we are working in a silo at times and there has got to be some platform where people can sit down at say "Or you're doing this, you're doing that and so on."

D: I wonder if there is a way to do that through the Quality Academy since their working on open communication as well? An overall better understanding between departments would be good.

I: And there is a lot in some of research I think in the Center for Innovation and I think there is a lot of stuff on the research shield side and if we could flip some of that more toward to the day to day administrative functions it would be beneficial.

C: I feel its filtered sometimes, like it's the cool, sexy things that we pull but there are a lot of issues that are more mundane that I think we could look at and say " oh we're dealing with the same problem or issue, lets partner and work together and get this diffused out" that's where it would be beneficial. I know nursing is working on a few things…